The Senate

The Health of Canadians - The Federal Role

Interim Report of the Standing Senate Committee on Social Affairs, Science and Technology

Chair:
The Honourable Michael J.L. Kirby

Deputy Chair:
The Honourable Marjory LeBreton

January 2002

Volume Three: Health Care Systems in Other Countries

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The Standing Senate Committee on Social Affairs, Science and Technology

Interim Report on
the state of the health care system in Canada

The Health of Canadians – The Federal Role
Volume Three – Health Care Systems in Other Countries

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ORDER OF REFERENCE

Extract from the *Journals of the Senate* of March 1, 2001:

Resuming debate on the motion of the Honourable Senator LeBreton, seconded by the Honourable Senator Kinsella:

That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report upon the state of the health care system in Canada. In particular, the Committee shall be authorized to examine:

(a) The fundamental principles on which Canada's publicly funded health care system is based;

(b) The historical development of Canada's health care system;

(c) Health care systems in foreign jurisdictions;

(d) The pressures on and constraints of Canada's health care system; and

(e) The role of the federal government in Canada's health care system;

That the papers and evidence received and taken on the subject and the work accomplished during the Second Session of the Thirty-sixth Parliament be referred to the Committee;

That the Committee submit its final report no later than June 30, 2002; and

That the Committee be permitted, notwithstanding usual practices, to deposit any report with the Clerk of the Senate, if the Senate is not then sitting; and that the report be deemed to have been tabled in the Chamber.

After debate,

The question being put on the motion, it was adopted.

ATTEST :

Paul C. Bélisle
Clerk of the Senate

SENATORS

The following Senators have participated in the study on the state of the health care system of the Standing Senate Committee on Social Affairs, Science and Technology:

The Honourable Michael J. L. Kirby, Chair of the Committee
The Honourable Marjory LeBreton, Deputy Chair of the Committee

and

The Honourable Senators:

Catherine S. Callbeck
Joan Cook
Jane Cordy
Joyce Fairbairn, P.C.
Alasdair B. Graham, P.C.
Wilbert Keon
Yves Morin
Lucie Pépin
Douglas Roche
Brenda Robertson

Ex-officio members of the Committee:
The Honourable Senators: Sharon Carstairs P.C. (or Fernand Robichaud, P.C.) and John Lynch-Staunton (or Noel A. Kinsella)

Other Senators who have participated from time to time on this study:
The Honourable Senators Banks, Beaudoin, Cohen*, DeWare*, Ferretti Barth, Grafstein, Hubley, Joyal P.C., Milne, Losier-Cool, Rompkey, and Tunney

*retired from the Senate

INTRODUCTION

In December 1999, during the Second Session of the Thirty-Sixth Parliament, the Standing Senate Committee on Social Affairs, Science and Technology received a mandate from the Senate to study the state of the Canadian health care system and to examine the evolving role of the federal government in this area. The Senate renewed the mandate of the Committee in the First Session of the Thirty-Seventh Parliament. The terms of reference adopted for the purpose of this study read as follows:

> *That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report upon the state of the health care system in Canada. In particular, the Committee shall be authorized to examine:*
>
> *a) The fundamental principles on which Canada's publicly funded health care system is based;*
> *b) The historical development of Canada's health care system;*
> *c) Publicly funded health care systems in foreign jurisdictions;*
> *d) The pressures on and constraints of Canada's health care system;*
> *e) The role of the federal government in Canada's health care system.*[1]

In response to this broad and complex mandate, in March 2001, the Committee re-launched its multi-year and multi-faceted study comprising five major phases. Table 1 provides information on each individual phase and their respective timeframes.

This document constitutes the Phase Three report of the Committee's study on health care. In accordance with the Committee's mandate, this report examines "publicly funded health care systems in foreign jurisdictions". More precisely, it describes and compares the way that health care is financed and delivered in several other countries and the objectives of national government health care policy in those countries. It highlights those policies from which Canada could learn.

[1] Debates of the Senate (Hansard), 2nd Session, 36th Parliament, Volume 138, Issue 23, December 16, 1999.

TABLE 1
HEALTH CARE STUDY:
INDIVIDUAL PHASES AND PROPOSED TIMEFRAMES

Phases	Content	Timing (Reports)
One	Historical Background and Overview	March 2001
Two	Future Trends, Their Causes and Impact on Health Care Costs	Winter 2002
Three	Models and Practices in Other Countries	Winter 2002
Four	Development of Issues and Options Paper	September 2001
Five	Hearings on Issues and Options Paper and Development of Final Report and Recommendations	Fall 2001/Winter 2002

The findings and observations contained in this report are based on a review of the relevant literature by the Committee's research staff, comparative studies commissioned with the assistance of Health Canada[2], videoconferences with health care officials, organizations and experts from the surveyed countries, and public hearings with Canadians experts in comparative international analysis in the field of health care.

In selecting countries to be examined, the Committee did not want to limit its study to health care systems that are similar to the Canadian model. We wanted to look at a variety of models, including those systems which are quite different from Canada's health care system but from which we could learn a great deal given that these countries have been actively involved in various health care reforms. Given the limited time and resources at its disposal, the Committee decided to review the health care system of the following countries: Australia, Germany, the Netherlands, Sweden, the United Kingdom and the United States. The Committee also reviewed the operation of medical savings accounts systems (MSAs) in various countries.

[2] Two studies were commissioned by the Committee. Ake Blomqvist, Professor of Economics at the University of Western Ontario, prepared a paper describing the Swedish health care system and entitled International Health Care Models: Sweden. Colleen Flood, Mark Stabile and Carolyn Hughes Tuohy, respectively professors at the Faculty of Law, Department of Economics and Department of Political Science, at the University of Toronto, prepared a document entitled Lessons From Away: What Canada Can Learn From Other Health Care Systems. Their paper provides a thorough review of the health care systems in place in Australia, the Netherlands, New Zealand, the United Kingdom and the United States. These two studies are available on the Committee's Website at the following address: http://www.parl.gc.ca/common/Committee_SenHome.asp?Language=E&Parl=37&Ses=1&comm_id=47.

This report consists of eight chapters.[3] Chapter One through Chapter Six describe the main characteristics and particularities of the health care systems in Australia, Germany, the Netherlands, Sweden, the United Kingdom and the United States respectively. These chapters all have the same structure and address the following issues: government responsibility for health care; health care insurance and coverage; funding for health care; management and provision; and, particularities. The information provided in these six chapters is presented in comparative terms with respect to the Canadian experience. Chapter Seven reviews the system of MSAs established in Singapore, South Africa and the United States, as well as the proposals put forward in Hong Kong. Finally, Chapter Eight provides a comparative review of the experience gained elsewhere.

[3] In this report, the testimony received by witnesses and printed in the Minutes of Proceedings and Evidence of the Standing Senate Committee on Social Affairs, Science and Technology will be hereinafter referred to only by issue number and page number within the text.

CHAPTER ONE:

HEALTH CARE IN AUSTRALIA

1.1 Government Responsibility

Like Canada, Australia has a federal system of government. As in Canada, health care in Australia is a shared responsibility between the national (or Commonwealth) government and sub-national governments (six States and two Territories). In Australia, however, the Commonwealth government has a stronger role in health care than is the case in Canada. While provincial governments in Canada have far greater fiscal leverage in health care than does the federal government, States and Territories in Australia are largely dependent on the Commonwealth government for health care funding. As in Canada, local governments (municipalities) in Australia play a relatively small role in health care.

- The **Commonwealth government** is responsible for public policy making at the national level in the fields of public health, research and national health information management. The Commonwealth government operates "Medicare", the national, publicly-funded health care insurance plan in Australia, and regulates the private health care insurance industry. It also finances and regulates residential aged care (nursing homes) and, jointly with States and Territories, it funds and administers some community-based care and home care. Commonwealth funding for health care is derived from general taxation plus a dedicated health care levy of 1.5% on taxable income.

- The **State and Territory governments** have primary responsibility for the management and delivery of publicly insured health services within their jurisdiction. As such, they deliver public acute and psychiatric hospital services and a wide range of community and public health services including school health, dental care, maternal and child health. State and Territory governments are also responsible for the regulation of health care providers as well as for the licensing and approval of private hospitals. Health care funding by States and Territories is derived mostly from grants from the Commonwealth government, as well as from general taxation and user charges.

- **Local governments** are responsible for health promotion and disease prevention programs (such as immunization), and environmental health services (such as sanitation and hygiene).

1.2 Health Care Insurance and Coverage

Medicare in Australia, which is operated by the Commonwealth government, is a compulsory regime that provides universal coverage to all citizens. Public health care

insurance is broader in Australia than in Canada as it covers physicians, hospitals, prescription drugs and some community-based care and home care. In contrast to Canada, user charges and extra-billing may be required for publicly insured health services. More specifically, Australian Medicare is made of three main components:

- The Medical Benefits Scheme (MBS) ensures access to physician services (outside of hospitals). The MBS lists a wide range of physician services and stipulates the fee applicable to each item (the "scheduled fee"). The MBS reimburses only 85% of the doctors' scheduled fee. In other words, Australian physicians may extra-bill. When doctors bill Medicare directly ("bulk bill"), they accept the 85% level as full payment and the patient pays nothing. When doctors charge more than the scheduled fee, the patient must pay the difference between the Medicare benefit and the scheduled fee and then claim reimbursement from Medicare or alternatively obtain from Medicare a cheque made out to the physician. However, a safety net provision applies to MBS: once patients have paid A$276 in physician fees in a given year (about $229CAN), they are exempt from further charges. Private insurance is not allowed to provide coverage for physician services that are publicly insured or for the gap between Medicare and the fee charged by the doctor. Relatively few physicians bill patients more than 85% of the MBS schedule.[4] Concessional patients (mostly social security recipients and veterans) are not required to pay any extra-billing.

- The Australian Health Care Arrangements (AHCAs) provide the basis for funding by the Commonwealth government to the States and Territories for hospital services. Funding by the Commonwealth government takes the form of annual block grants whose amounts are negotiated in five-year agreements with the States and Territories, who in return agree not to allow user charges for public hospital services. The extent of public coverage for hospital care depends on whether a patient elects to be a public patient or a private patient. Full coverage for hospital care is provided to public patients in State and Territory owned hospitals or in private non-profit hospitals. Public patients are also entitled to free hospital care in for-profit hospitals which have made arrangements with governments to care for public patients. However, when an individual chooses to be a private patient in a public hospital (in which case he/she has the ability to choose his/her own doctor) or goes to a private hospital, the Commonwealth government pays only 75% of the scheduled hospital-based physician fee. All other costs are the responsibility of the patient. The safety net that applies to physician services under the MBS and which limits the amount paid by the patient in a one-year period does not apply to Medicare benefits for hospital services. Private health care insurance is allowed to cover the difference between 75% of the scheduled fee and the actual fee charged. Private

[4] It is estimated that 70% of all physician services are billed directly.

insurers can also provide additional benefits for hospital accommodation and other hospital charges.

- The Pharmaceutical Benefits Scheme (PBS), which is based on a national drug formulary, provides free access to drugs prescribed outside of hospital, subject to annual thresholds.[5] Under the PBS, eligible people fall into two categories: general patients and concessional patients. General patients are required to pay a maximum of A$20.60 per prescription ($17.10CAN) up to a total of A$612 per year (about $508CAN); beyond that limit, they are required to pay only A$3.30 per prescription ($2.80CAN). Concessional card holders pay A$3.30 per prescription. Once the safety net threshold is reached for concessional patients (A$166), drugs are fully paid by the Commonwealth. If the prescription involves a more costly but equivalent brand, the subsidy may be limited to the lower cost brand (this is called the minimum pricing policy). Individuals must pay for drugs not listed on the national formulary in full and, also in full, for drugs that are priced below the co-payment amount. It is estimated that about 75% of all prescriptions issued in Australia are subsidized under the PBS.

As in Canada, some services are not covered under Australian Medicare, such as cosmetic surgery and services provided under workers' compensation insurance and private insurance can cover allied health/paramedical services (such as physiotherapists' and podiatrists' services), as well as some aids and devices. However, in contrast to Canada, private health care insurance in Australia both complements and competes with Medicare since private insurers may cover the same benefits as under the public plan. Australians can supplement their Medicare benefits through private health care insurance, but they cannot opt out of the publicly-funded system since they continue to pay their taxes.

The Commonwealth government is responsible for regulating private health care insurance and it requires that premiums be community rated. This means that private insurers must establish a common premium structure for all enrolees regardless of their health status. In other words, they cannot charge higher rates for high risk individuals such as the aged or the chronically ill. Community rating ensures that private insurance is available to a wide range of people in the community. This in turn necessitates a system of reinsurance, designed to ensure that insurers with high proportions of aged and chronically ill customers do not suffer competitive disadvantage. The Commonwealth government has also introduced a number

> ***(...) health insurance in Australia is fully community rated, which I think reflects its social role as far as governments are concerned. By "fully community rated" I mean that there is no premium discrimination against people by virtue of age, sex, state of health or potential health risk. The only restriction is a 12-month waiting period after joining for pre-existing ailments. At the end of 12 months, benefits are fully payable for pre-existing conditions as well as for conditions that occur after joining. I think you can see from that that there is a very strong social component of the private sector in Australia, and it does link in quite well with the public sector.***
>
> ***Russell Schneider, Chief Executive Officer, Australian Health Insurance Association (21:5)***

[5] Like in Canada, prescription drugs dispensed in public hospitals are free of charge.

of tax-based measures to encourage people to purchase private health care insurance in order to counteract a long-term trend of decreasing take up of private insurance. Overall, there are about 40 private health care insurance funds registered in Australia.

1.3 Funding for Health Care

As in Canada, some 70% of health care spending is financed by the public sector (46% by the Commonwealth government and 24% by State and Territory governments) and 30% by the private sector (see Appendix). The Commonwealth government finances a greater proportion of Australian health care than does the federal government in Canada. The Commonwealth government in Australia is the primary public insurer of prescription drugs and physician services. It also funds some 50% of hospital expenditures.

Medicare is financed largely by general taxation revenue, some of which is raised by an income-related Medicare levy at the national level. This Medicare levy is paid by individuals at a basic rate of 1.5% of taxable income above certain income thresholds. Individuals who do not pay any income tax do not pay the Medicare levy (but they are entitled to full coverage under Australian Medicare). Taxpayers with high incomes who do not have private health care insurance pay an additional 1% of taxable income as part of the levy. The Medicare levy accounts for approximately 27% of Commonwealth funding for Medicare and for about 8% of total health care spending in Australia.

The Commonwealth government provides funding for Medicare in three ways: 1) through subsidies for prescription drugs and private medical and optometric services; 2) grants to States and Territories for the purpose of health care; 3) specific grants to State and Territory governments and other bodies. State and Territory governments supplement Commonwealth grants by raising their own revenue through taxation.

Residential aged care is financed by the Commonwealth government by means of subsidies paid to service providers, based on the level and type of care needed by the individual. Community care services for the frail aged and the disabled are jointly funded by both the Commonwealth and State/Territory governments.

About 25% of State and Territory government budgets are allocated to health care and about 69% of those funds go to public hospitals.

1.4 Management and Provision

As in Canada, the majority of doctors are self-employed. Most primary care provided by general practitioners in private practice is reimbursed on a fee-for-service basis. A small proportion of physicians are salaried employees of Commonwealth, State/Territory or local governments. General practitioners in primary care act as gatekeepers, with access to specialist medical services being available only on their referral.

Hospital care is provided by a mix of public and private institutions. Public hospitals remain the major providers of care. Public hospitals include hospitals established by State/Territory governments and hospitals established by religious or charitable bodies but now directly funded by government (private non-profit hospitals). Specialists in public hospitals are either salaried or paid on a per-session basis. Salaried specialist doctors in public hospitals can treat some patients in these hospitals as private patients, charging fees to those patients and usually contributing some of their fee income to the hospital.

There are a small number of private for-profit hospitals built and managed by private firms providing public hospital services under arrangements with State/Territory governments. However, most acute care beds and emergency outpatient clinics are in public hospitals.

Private hospitals tend to provide less complex non-emergency care, such as simple elective surgery. However, some private hospitals are increasingly providing complex, high technology services. Like public hospitals, some private facilities provide same-day surgery and other non-inpatient operating room procedures. Public and private hospitals are not perfect substitutes for each other, however, as accident and emergency facilities, as well as technologically complex and highly specialized services, remain concentrated in the public sector.

A significant proportion of other health care providers are self-employed. In addition, there are many independent pathology and diagnostic imaging services operated by doctors.

1.5 Particularities

Australia shares many similarities with Canada: both countries have the same political system of government, they have similar geography and they enjoy similar health outcomes. The public share of total health care spending is the same in Canada as in Australia (around 70% - see Appendix). However, Australia manages to spend much less on health care as a percentage of GDP (8.5%) than does Canada (9.5%). Australian Medicare is a single

> ***By analogy to Canada, we are similar. We have a somewhat smaller percentage of GDP spent on health. It is 8.5 per cent. We have a system that is much more complex in its federal state relation between federal government and state governments, with the federal government running directly reimbursements for medical services and pharmaceuticals and with the states running the hospitals, as in the Canadian provinces. There are large transfers of money from commonwealth government to state governments, unlike your arrangements where the provinces raise their own. We have a much bigger private sector than in Canada, with a strong private health insurance system that has strong government support – both financial and political –underpinning that health insurance system. It finances a wide network of private hospitals in particular.***
>
> ***I think the similarities between us are probably greater than the differences compared with other countries.***
>
> ***Dr. Richard Madden, Director, Australian Institute of Health and Welfare (21:4)***

national program, whereas Canadian Medicare is an amalgam of separate provincial and territorial health care insurance plans. In Australia, the national government plays a stronger role in health care than does its Canadian counterpart and it is more able to take unilateral action when reforms are undertaken.

Australia's health care system differs from the Canadian in the following main ways: 1) public coverage is much broader in Australia; 2) user charges and extra-billing for publicly insured services provide non-tax sources of revenue to the health care sector; 3) private insurance both complements and competes with public coverage. One factor that may have contributed to the ability of the Australian health care system to provide broader coverage is the willingness to employ user charges and extra-billing and to allow private insurance.

In Australia, the Commonwealth government operates a national Pharmacare program, the PBS. It is the view of the Commonwealth government that the PBS has succeeded in containing the cost of prescription drugs for a number of reasons. First, since 1993, the PBS does not list a drug on its formulary unless it receives a positive assessment with respect to safety, quality, effectiveness and cost-effectiveness. Second, higher user charges are required for brand-name drugs when generic copies are available. And third, a "reference pricing" mechanism ensures that the government subsidizes only up to the price of a lower-priced drug that is therapeutically interchangeable with, or equivalent to, the prescribed drug.

Overall, the PBS subsidizes about 75% of all prescriptions in Australia, and the average subsidy is 57% of the prescription cost. According to Colleen Flood, Professor of Law at the University of Toronto, although this is a significant contribution by patients, it is in the context of a coherent national system that ensures access for those to whom cost would be a barrier.[6]

Physicians in Australia may extra-bill. Therefore, they are not wholly dependent on the government for remuneration. They can bill patients at rates of their own choosing above the scheduled fee. As a result, they have accepted a considerably lower level of public remuneration than is the case in Canada.

It is legal in Australia to obtain private health care insurance to cover: 1) part of the cost of physician services provided in public and private hospitals to private patients and that is not covered under Medicare; 2) all other hospital costs incurred by private patients in public or private hospitals. However, private insurance is prohibited for physician services rendered outside of hospitals. It has been suggested that this prohibition has created some "perverse" side-effects (see below).

The Commonwealth government strongly encourages Australian residents to acquire private health care insurance. More specifically, it offers holders of private health care insurance a subsidy of 30% of the cost of that insurance. This rebate for private insurance premiums is available to all, regardless of income, as a 30% refundable tax credit. This rebate represents an average of A$800 in savings annually (or about $600CAN). The

[6] Colleen Flood, Profiles of Six Health Care Systems: Canada, Australia, the Netherlands, New Zealand, the UK, and the US, 30 April 2001, p. 12.

objective of the Commonwealth government is to have about one-third of the population participate in private insurance schemes.

Since July 2000, the 30% rebate legislation stipulates that the private insurance company must offer policies with no gaps between the medical scheduled fee and the fee charged by doctors. This provision, called the "no gap/known gap", is intended to reduce the gaps and to make the extra charges known to patients. Prior to that reform, private insurance covered only scheduled medical fees, and actual fees charges could be much higher: two patients could be given exactly the same treatment for which the private patient received a large bill not reimbursed by private insurance, while the publicly insured patient never saw a bill."[7]

A "Lifetime Health Cover" was also introduced in July 2000. Under this system, individuals aged 30 years or less who purchase private health care insurance pay lower premiums throughout their life compared with someone who joins later in life. Over the age of 30, a 2% increase in premiums over the base rate is tacked on for every year a person delays in joining. This initiative is expected to reduce premium rates by encouraging more younger and healthier people to take out private insurance and by discouraging people from joining prior to treatment and leaving following the treatment.

According to Carolyn Hughes Tuohy, Professor, Department of Political Science at the University of Toronto, it remains unclear whether a very large public subsidy for private health care insurance is an effective use of public funds. She suggests that directing an equivalent expenditure toward public treatment in public hospitals would be more effective.[8]

During the Committee's hearings, Dr. Roger Kilham, from the Australian Medical Association, suggested that private insurance for hospital services in Australia has resulted in rationing in the public system (in the form of longer waiting times) and in queue jumping:

> *(...) there is more rationing in the public sector. People do not get access. It is very common to meet someone who has waited five years to get a hip replacement or even longer for a knee replacement. There is a lot of rationing in the public sector. We call private health insurance "queue-jumping insurance." Basically, it buys a place further up the queue. That is the reality and that is why people like it. They can jump queues if they have the money to do so.*[9]

More public funding was provided to deal with to longer waiting lists. According to Russel Schneider, CEO of the Australian Health Insurance Association, this did not solve the problem:

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[7] Jane Hall, "Incremental Change in the Australian Health Care System," Health Affairs, May/June 1999, p. 95-110.

[8] Carolyn Hughes Tuohy, The Political Economy of Health Care Reform: A Cross-National Analysis, 30 April 2001.

[9] Dr. Roger Kilham (21:8).

Waiting lists at public hospitals are a political problem that varies from time to time. Governments have tried to solve the problem by putting more financial resources into the public sector, but the tendency seems to be the same as it is anywhere else in the world. More money does not reduce waiting lists. All it does is allow those people who were not on the waiting list before to get put on to it. [10]

This was echoed by Dr. Roger Kilham who noted:

Our experience is every time the state government announces a program to deal with waiting times, the waiting times get longer. Because we have this ability within the system to switch from the public to the private and back again, each time the government says it will spend more money to reduce the waiting lists, expectations of service in the public sector increase and people then rejoin the public sector lists. In reality, programs to reduce waiting times do not work; they only relocate the business in the public sector. [11]

Russel Schneider also indicated that restricting private insurance to in-hospital services has created "perverse incentives":

One of the difficulties is that all non-hospital medical treatment is funded by a single source, which is the government, and possibly a patient care payment. Health insurance does not apply to non-hospital medical treatment.

That leads to some perverse incentives within the system, because from both the doctor's point of view and the patient's point of view, the level of rebate for a particular service will be greater if that service is performed in an in-hospital setting, than if that same service were performed outside the hospital. That could probably be a criticism of our system.

It also makes it difficult for insurers to exercise effective cost-containment by the support of primary care interventions, or primary care treatment, for their populations. Consequently, there is a defect in the system. This is a very politically controversial statement, but we would achieve a better health care system if we were able to redirect the energies of the private sector and the public sector into primary care interventions, rather than funding high-cost, high-tech hospitalization, which is where insurers are confined at the moment. [12]

---

[10] Russel Schneider (21:33).
[11] Dr. Roger Kilham (21:33).
[12] Russel Schneider (21:10).

CHAPTER TWO:

HEALTH CARE IN GERMANY

2.1 Government Responsibility

Germany is a federal republic consisting of a national (federal) government and 16 state governments (known in Germany as Länder). Decision-making powers with respect to health care are shared between the two levels of government[13]:

The **federal government** provides the regulatory framework for health care at the national level. National health care policy rests essentially on the principles of statutory social insurance (often referred to in Germany as the "Bismarck model"). The federal government has the authority to regulate Sickness Funds (described below) and private health care insurance. It is also responsible for long term care policy as well as for reference pricing policy with respect to prescription drugs.

The **Länder** are responsible for the delivery of health care. They own many hospitals, along with local governments and charitable organizations. They are responsible for maintaining all hospital infrastructure in their jurisdiction, independently of actual ownership. Länder have the authority to finance medical education and supervise health care professionals. They are also responsible for public health, health promotion and disease prevention.

2.2 Health Care Insurance and Coverage

Health care insurance in Germany is organized into three different schemes: 1) Sickness Funds; 2) private health care insurance; 3) public coverage by the federal government for military personnel, police officers and social welfare recipients.

Public health care insurance in Germany is administered by some 453 Sickness Funds. These Sickness Funds are private non-profit organizations that are structured on a regional and/or occupational basis. Sickness Fund membership is compulsory for employees with gross income lower than DM 77 400 (data for 2000) or around $63,000 CAN and is voluntary for those above that level. Sickness Funds provide health care coverage both to members and to their spouses/dependants. Although all Sickness Funds are regulated at the federal level through what is known as the "Social Code Book," they are essentially run by representatives of the employees and employers.[14]

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[13] Following unification in 1990, the health care system of the former German Democratic Republic was reformed to match that of the Federal Republic of Germany.

[14] While Sickness Funds are private non-profit organizations, they are regulated by government to a point that they can be more accurately described as quasi-public entities.

Under national legislation, Sickness Funds have the right to raise contributions from their members and to determine their own contribution rate. Contributions are based on taxable income and are shared equally between the employee and his/her employer. In 2000, members of the Sickness Funds and their employers were required to contribute jointly an average of 13.5% of monthly gross income (or 6.75% each). For employees with an income below a certain threshold, only employers make contributions.[15]

> *(...) the German statutory health care system is part of the German social security system. It works on the same principle as the pension system and the unemployment system. This means that the financing of the system works on the basis of contributions. Contribution rates are carried by employees and employers, each carrying half of the contribution. When people retire, the contribution is paid from the pension system.*
>
> *We have a system that is financed without taxes. It is financed on a contribution base. This is very important. It is a system that is organized by law but is not run by the government. Our system is different from the typical national health care system.*
>
> *This system is carried by the sickness funds. The sickness funds are not government parts. They are not private companies. I would describe them as non-profit institutions which work on the basis of federal law but have their own contribution rates.*
>
> *Georg Baum, Director General, Head of Directorate, Health Care, German Health Ministry (20:5).*

Public health care coverage is much broader in Germany than in Canada. In fact, the German health care system is among the most comprehensive in the world. Sickness Funds are required under the Social Code Book to provide coverage for: physician services, hospitals, prescription drugs, diagnostic services, dental care, rehabilitative care, medical devices, psychotherapists, nursing care at home, medical services by non-physicians (physiotherapists, speech therapists, occupational therapists, etc.) and income support during sick leave.[16]

In Contrast to Canada, user charges may be required for publicly-insured health services. In 2000, user charges, whose levels are determined in national legislation, applied to the following:

- prescription drugs (between DM 8 to 10 or $7-8 CAN depending on pack size or 100% of price above the reference price);
- dental care (a coinsurance payment that varies from 35% for some services to 50% on crown and denture treatment, depending on the case);
- hospital services (DM 17 per day or $14 CAN);
- rehabilitation services (DM 17 per day or $14 CAN), and
- ambulance transportation (DM 25 per trip or $20 CAN).

[15] In the case of retired and unemployed people, the retirement and unemployment funds take over the financing role of the employer.

[16] Psychologists specialized as psychotherapists have become members of the physicians' associations and therefore no longer have the status of non-physicians.

User charges are subject to an annual threshold: once they have reach this limit, Sickness Fund members are exempt from further charges. Some individuals are exempted from paying any user charges, such as people with low income, those receiving unemployment benefits or on social welfare, children and the chronically ill.

Private health care insurance is available to individuals whose annual gross income is superior to DM 77 400 ($63,000 CAN) and who have voluntarily opted out of their Sickness Fund. Private coverage is currently offered by 52 private insurance companies. Since re-entry of privately insured people into Sickness Funds is not permitted under ordinary circumstances, private insurers are obliged to offer an insurance policy with the same benefits as the Sickness Funds at a premium that is no higher than the average maximum contribution in the Sickness Funds. However, premiums in the private health care insurance sector are risk-related and reflect the medical history of the insured individual (this contrasts with Australia where premiums charged by private insurers are community-rated). Further, unlike Sickness Funds, private health care insurers require that separate premiums be paid for spouses and dependants.

Private health care coverage is also available to self-employed people who are excluded from the Sickness Funds. Private insurers also provide coverage to public servants who are also excluded *de facto* from participating in Sickness Funds as their health care bills are reimbursed at 50% by the federal government (private insurance covers the remainder). Finally, private health care insurance can offer supplementary benefits to members of the Sickness Funds (Sickness Funds are not legally allowed to offer these extra benefits).

Overall, 88% of the German population is covered under Sickness Funds: 74% are mandatory members and their dependants, while 14% are voluntary members and their dependants. Some 9% of the German population are covered under private health care insurance, mostly high-income earners; another 2% are insured by governmental insurance (police officers, military members, etc.). Less than 1% of the population has no health care insurance at all (according to testimony, they are usually self-employed people who have decided not to purchase private insurance).

2.3 Funding for Health Care

The public share of overall health care spending is higher in Germany (75%) than in Canada (70%). Private sector funding in Germany accounts for the remaining 25% (see Appendix).

Contributions to the Sickness Funds constitute the main source of financing health care in Germany (70%). User charges by patients fund the next largest share (12%), while the balance of funding comes from general taxation (7%), private health care insurance (7%) and other sources (4%).[17] General taxation is used to reimburse some of the health care expenditures incurred by public employees, persons on welfare, subsidies for the farmers' funds.

[17] OECD Health Data (2000).

2.4 Management and Provision

In Germany, a national body, called the "Advisory Council for Concerted Action in Health Care," is responsible for setting guidelines with respect to the rate of growth of health care spending. These guidelines must be taken into account in the determination of physician remuneration and of hospital budgets.

Primary care is organized almost exclusively on the basis of office-based physicians. The majority of physicians have solo practices – only 25% share a practice. Patients are free to select a Sickness-Fund-affiliated doctor of their choice. German doctors do not act as gatekeepers of the system and patients can go directly to specialists practising outside hospitals. As a result, both general practitioners and specialists carry out primary care. Primary care doctors, however, do control access to hospital care.

Primary care physicians are paid on a fee-for-service basis. At the beginning of each year, in each Länd, the Sickness Funds and the regional medical associations negotiate an overall remuneration package. Then, the medical associations distribute this total allotment according to a Uniform Value Scale (UVS). This scale lists all medical services that can be provided by physicians and allocates a point value to each service. At the end of each quarter, every office-based physician invoices his/her association for the services delivered. Physicians, however, do not know exactly how much they will earn since the monetary value of a single service may decline if physicians are performing too many services in any one category. As in Canada, physicians cannot extra-bill patients insured under Sickness Funds.

Although Sickness Funds and private insurers use the same scale for remunerating primary care physicians, they each assign different point values. Private insurers generally provide a higher remuneration for the same services compared to the Sickness Funds. Moreover, physicians treating privately insured patients are not subject to budget caps as occurs with Sickness Funds. Therefore, physicians obtain a higher remuneration when treating privately insured individuals in Germany. Further, it is permissible for physicians to extra-bill privately insured patients.

There are about 2030 general hospitals in Germany: around 790 (39%) are publicly-owned, 820 (40%) have private non-profit status and 420 (21%) are private for-profit hospitals. The Länder are responsible for developing all "hospital plans." These plans determine how many hospitals are required in each region. They also list for every hospital the specialities that are necessary, and the number of beds per specialty.

While the Länder are responsible for the flow of capital investment into the hospital sector, the Sickness Funds/private insurers are responsible for funding hospitals' operating costs. Prior to the 1990s, hospital remuneration by Sickness Funds was done through a per diem rate which was uniform within a hospital and independent of actual diagnosis, amount of care, or length of stay. Rates varied among hospitals depending on their size and structure and thus on the spectrum of services available. As a result, the general per-diem rate led to wide cross-subsidization across medical departments in hospitals.

In the 1990s, the federal government introduced several changes to hospital financing. Remuneration of hospitals now consists of three parts: 1) a general per diem typically covering food and lodging; 2) a ward specific compensation for additional resources spent in a given hospital department; and 3) a lump-sum remuneration for specialized treatment services (such as cancer treatment and organ transplants).[18]

Doctors employed in public hospitals are paid on a salary basis. Non-profit hospitals and the doctors working in them receive payment in the same fashion as their public hospital counterparts. Arrangements in the private for-profit hospitals are somewhat different. There, doctors are paid on a fee-for-service basis according to a schedule that is laid out by the federal government. A part of each fee received by doctors working in private for-profit hospitals is given to the hospital.

As in Australia, national legislation in Germany enforces therapeutic reference-based pricing for prescription drugs as the reimbursement method under the Sickness Funds. Reference prices are set through an ordinance issued by the federal minister of health. To contain drug costs further, in 1996 the federal government introduced a list of drugs which were not entitled to public reimbursement. There are plans to develop a positive list of reimbursable prescription drugs (national formulary).

2.5 Particularities

The health care system in Germany shares many similarities with the system in the Netherlands (see Chapter 3), but it is very different from that of Canada. First, social insurance (based on employee and employer contributions which vary with income) is the main source of health care funding in Germany and not general taxation revenue as in Canada. Second, the revenue generated from these income-related contributions is not managed by government but by the Sickness Funds themselves. Third, public health care coverage is more comprehensive in Germany than in Canada. Fourth, user charges are permitted for a variety of publicly-funded health services in Germany, while they are prohibited in Canada. Finally, private health care insurance plays a more important role in Germany than in Canada.

Privatization is another important feature of the German health care system. As in Canada, physicians have their own private practice and community pharmacies operate privately. The hospital sector in Germany is a mixture of public, private non-profit and private for-profit hospitals. Like Australia, but unlike Canada, private health care insurance in Germany coexists alongside the statutory Sickness Funds.

Three elements of the German health care system are of particular interest. The first concerns competition among Sickness Funds. The second relates to the lack of integration between the primary care sector and the hospital sector. The third element is the introduction of statutory long-term care insurance in 1994.

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[18] This system is similar to the Diagnostic Related Groups currently in place in the United States (see Chapter 6).

2.5.1 Competition Among Sickness Funds

Traditionally, individuals had no choice over their Sickness Funds and were assigned to the appropriate fund based on geographical and/or job characteristics. This mandatory distribution of fund members led to great variation in contribution rates due to different income and risk profiles. Since 1996, however, individuals enrolled in a regional or employment-based Sickness Fund have had the right to choose another Sickness Fund. To ensure a level playing field, the federal government also established in the same year a "risk structure compensation scheme" that requires all Sickness Funds to equalize differences in contribution rates (due to different income levels) and expenditures (due to age and sex). The free choice of fund and the risk structure compensation scheme have led to members moving between funds, from those funds with higher than average contribution rates to those with lower than average rates, as well as to a narrowing of the gap between the various contribution rates.

> *We have an equalizing financial distribution system between the sickness funds. With this instrument, we are able to balance the contributions so they are more equal. At the moment, we are making additional efforts to create a more sophisticated money distribution system between the sickness funds.*
>
> *We have four factors. They are income, which is one aspect of money distribution; sex: male or female; the number of people insured by one contribution payer - we have the family system, and age. Those are the four relevant factors for one sickness fund to pay into another sickness fund.*
>
> *Georg Baum, Director General, German Health Ministry (20:18)*

2.5.2 Lack of Integration

Before 1993, primary care physicians were not allowed to treat patients in hospitals and hospitals could not provide outpatient surgery and services, which were provided by general practitioners, specialists or dentists. German hospitals had to concentrate on inpatient care. This led to many inefficiencies, including duplication of technical equipment and repetition of diagnostic tests.

Hospitals in Germany have been allowed to offer surgery on an ambulatory or day-case basis only since 1993. As well, general practitioners and specialists have been given access to a certain number of hospital beds to perform treatment inside hospitals. It has now become easier for doctors involved in providing ambulatory services to be involved in inpatient care and there are also greater possibilities for the joint acquisition of high cost technical equipment.

2.5.3 Long-Term Care

Historically, long term care in Germany was only available in hospitals. Therefore, at times people were admitted for non-medical reasons. To rectify this situation, in 1994 the federal government introduced a separate piece of legislation regarding statutory long-term care insurance. All members of Sickness Funds as well as people with full-cover private health care insurance were declared mandatory members of the long-term care insurance scheme, which is administered by both the Sickness Funds and the private

insurers. Members and their employers must contribute jointly 1.7% of monthly gross income (or 0.85% each).

Everybody with an entitlement to nursing care is given the choice between monetary support for home care delivered by family members or professional services as in-kind benefits. In addition, caregivers who care for family members at home can attend training courses free-of-charge and are insured against accidents, invalidity and old age. For persons needing long-term, institutionalized nursing care, benefits are available for day or night clinics, as well as for institutionalized care in old age or special nursing care home.

CHAPTER THREE:

HEALTH CARE IN THE NETHERLANDS

3.1 Government Responsibility

The Netherlands has a unitary system of government.[19] It is, however, a highly decentralized country with 12 provinces and 646 municipalities. Each province has its own representative body and its own responsibilities in many fields of jurisdiction. However, their role in health care is rather limited. Health care policy-making in the Netherlands has to a great extent been monopolized by the national government.[20] This contrasts to Canada, where health care is a shared responsibility between the federal government and the provinces.

The national government of the Netherlands has responsibility for, and financial control over, most aspects of the health services. In contrast to Canada, the government's financial contribution to health care through general taxation is relatively low, accounting for less than 10% of total health care spending.[21] Like in Germany, most of the public funds allocated to health care in the Netherlands are raised by the social insurance system through employers' and employees' contributions.

> ***The Dutch have a unitary state, yet they do not have direct provision of services. What they have - and it is not only in the health sector but also across other policy sectors - is something called steering or guiding. In fact, even when one uses the word "control," it certainly guides behaviour, and there can be penalties, it does not have that same feeling of lockstep control because there is so much persuasion involved in the system.(...), if the government notices a pattern shifting, it will think about the impact of that and then tinker with ways to raise or lower that pattern.***
>
> ***Dr. James Björkman, International Institute of Social Studies of the Netherlands (15:19)***

The role of the Dutch government in regulating the health care system is a significant one. Amongst other things, it requires certain groups to buy insurance, closely regulates insurers for fiscal stability, monitors negotiations between purchasers and providers, and sets a target budget that signals its wishes to all parties concerning health care expenditures.

3.2 Health Care Insurance and Coverage

The health care system of the Netherlands is similar to the German system, but very different from that of Canada. There is no single public health care insurance plan

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[19] The Netherlands is a constitutional monarchy with a written constitution (last revised in 1983). Executive power lies with the Crown and legislative power rests with both the Crown and the bicameral Parliament.

[20] Maarse, J. A. M. (Hans), "The Health System of the Netherlands" in Health Care and Reform in Industrialized Countries (University Park, Penn.: The Pennsylvania State University Press, 1997), pp. 135-36.

[21] Ministry of Health, Welfare and Sport, Health Care Insurance in the Netherlands, July 2000, p. 7.

covering everyone as there is in Canada, but a mixture of public, social and private health care insurance schemes. Every Dutch citizen is guaranteed access to health care insurance, although certain categories of people (high income earners) are not obliged to purchase it (yet just about all of them do). Unlike the situation prevailing in Canada, user charges in the Dutch health care system are not perceived as impeding access to health care and may be required at the point of service.

In the Netherlands, a distinction is made between what is seen as "normal medical care" and the "exceptional costs" associated with long-term care or high-cost treatment, where the risk is such that it cannot be borne by individuals or adequately covered by private insurance. More specifically, there are three different categories of health care insurance:

3.2.1 Insurance for Normal Medical Care

The first category of health care insurance deals with "normal medical care." Normal medical care includes all medical and surgical treatment by general practitioners and specialists, some dental care, and prescription drugs. Coverage for normal medical expenses is available through a variety of health care insurance plans, some of which are public and some of which are private (and voluntary). More specifically, there are three forms of insurance covering normal medical expenses:

1. Public coverage is governed by national legislation, the Health Insurance Act, and is provided through social health care insurance or "Sickness Funds." Sickness Funds are private non-profit institutions that cover everyone who earns below a designated income level (for 2000 this was set at 64,600 Dutch guilders, or about $42,000CAN). Sickness Fund membership for this group of the population is mandatory, and more than 64% of the Dutch population currently belong to these funds. The employee and his/her employer must pay a premium whose maximum level is fixed by regulation. Patients may also incur user charges for health services covered by their Sickness Funds, subject to an annual threshold (200 Dutch guilders or about $130CAN). There are over two dozen Sickness Funds. They used to be regionally based, but as a result of reforms undertaken over the past 15 years each Sickness Fund now serves the entire country. People can select which fund they wish to join and the funds compete with one another for members. As in Germany, the funds pay health care providers directly the agreed fee for a given service, so for Sickness Fund members no exchange of money takes place between patients and doctors (other than user charges, where applicable).

2. People earning over the prescribed income limit are entitled to purchase voluntary private health care insurance, and most of them do (31% of the Dutch population). Those who have private

insurance do not have to pay the income-related contribution that finances the Sickness Funds. Private insurers are both non-profit and for profit. Some of the non-profit insurers are owned by the Sickness Funds while others are "mutual" insurers, owned by their shareholders, or run by large multinational corporations. The for-profit insurers are mostly large, multi-line insurers whose activity is not limited to health care, but also include life, home and automobile insurance. People with private health care insurance pay providers for the cost of care and are subsequently reimbursed by their insurer. Private insurers must accept all those who apply for coverage that is equivalent to that offered under the Sickness Funds. User charges and premiums required in private health care insurance schemes are subject to national legislation.

3. The third form of coverage for normal medical expenses applies to civil servants employed at all levels of government, who make up the remaining 5% of the Dutch population. The scheme is mandatory and patients are generally reimbursed for 80-90% of their medical expenses. Coverage is slightly broader than that offered by the Sickness Funds (partial reimbursement is offered for dental crowns and bridges, contact lenses, chiropractic treatment, etc.) and is administered by 12 special private insurance arrangements.

3.2.2 Insurance for Exceptional Medical Care

The second category of health care insurance is provided under the *Exceptional Medical Expenses Act*. This is the only national, mandatory health care insurance plan, that covers the entire Dutch population. This scheme, which is often referred by its Dutch acronym "AWBZ," covers exceptional expenses such as long term care (nursing homes), mental illness, physical disability, etc. Anyone who is insured for normal risks by any other insurer is automatically entitled to benefits under the exceptional expenses scheme. In this way, people only deal with a single insurer who administers all their benefits regardless of the source of the funding. The entire population must pay into these funds regardless of whether or not they use the services that they cover. The premium is set at a percentage of the employee's wage and is paid by the employer. Patients may be required to pay user charges for some services. The national government also provides grants to insured people under certain conditions to cover some services and treatments (such as abortion clinics, intensive care at home, prenatal and perinatal tests, etc.).

3.2.3 Voluntary Supplementary Insurance

The third category is voluntary supplementary insurance for forms of care regarded as less necessary, and which are not included in either of the other two categories. This resembles supplementary health care benefits that are provided by private insurers in Canada and that cover health services not insured publicly.

3.3 Funding for Health Care

The table presented in the Appendix to this report provides some information on health care spending in selected OECD countries. The OECD records the public share of total health care spending in the Netherlands at 70.4% for 1998.[22] It is important to remember, however, that unlike Canada but as in Germany, the Dutch system for public health care funding is a form of social insurance. More precisely, the funds for the purpose of health care are raised through employers' and employees' contributions, not by general taxation. Social insurance funds are not managed by the Dutch government but by the Sickness Funds themselves. Less than 10% of total health care spending is generated through general taxation raised by the national government. The other sources of health care funding consist of private health care insurance premiums and user charges.

Sickness Funds are financed by three main sources. First, insured people and their employer must pay an income-related contribution whose maximum is set in national legislation. These income-related contributions are collected in a central pool which then distributes them to the various Sickness Funds. Second, since 1991, Sickness Fund members must also pay a nominal (flat-rate) contribution. This nominal contribution is set by each Sickness Fund and can therefore vary from fund to fund. This measure obliges the Sickness Funds to compete with one another. Finally, Sickness Funds receive an annual grant from the national government to cover the costs of some groups, primarily the elderly.

Health care for civil servants is funded through contributions from participants and employers. The participant pays both a nominal contribution and a percentage of the salary.

Private health care insurance premiums are voluntary, except when the policyholder is a pensioner or a person in a high-risk group. People in these groups are entitled to a standardized policy that is subsidized by the national government. Premiums required in private health care insurance schemes, as well as co-payments and deductibles, are based on the level of coverage that is purchased, subject to the limits established by national legislation.

The resources to cover the costs of the second category of insurance, the AWBZ scheme, are obtained from contributions and payments from the people insured. Contributions are collected together with income tax and represent a percentage of taxable income. The employer withholds the employees' contributions from their wages and pays them to the tax authorities. Insured people under the age of 15 are not liable for contributions. Funding for the AWBZ also includes direct national government grants, and user charges.

3.4 Management and Provision

As in Canada, most hospitals in the Netherlands are privately owned and operate on a non-profit basis. Many are affiliated with Protestant, Catholic or non-

[22] OECD Health Data (2000).

denominational religious orders. The budget for hospital and other institutional services and the fees for health care providers are set during centralized negotiations between representatives of insurers and providers.[23] Since 1983, Dutch hospitals have been funded using prospective annual global budgets negotiated with representatives of private insurers and the Sickness Funds. Prospective budgets are not linked to the volume of services provided, but depend on the size of the service area, the number of authorized beds and specialists and the number of contracts between the hospital and the insurers. These budgets apply to both public and private patients and cover nearly all costs incurred by a hospital apart from specialists' fees.[24] Although the Dutch government is not involved in the negotiations surrounding hospital budgets, it must give its approval before construction of new hospitals or other major hospital investments may be undertaken.

As in Canada, most general practitioners in Netherlands operate a private practice. Each Sickness Fund member must choose a family doctor to register with from the list of those that the fund has contracted with, and cannot change for a year. Family doctors then act as gatekeepers to the rest of the system. Sickness Funds pay family doctors on a capitation basis (an annual fee per person), the fee being uniformly set for the whole of the Netherlands by regulated negotiations between representatives of practitioners and insurers.[25] This contrasts with the situation in Canada, where general practitioners are remunerated on a fee-for-service basis and where the negotiations over physicians' remuneration also involve the government. Patients with private insurance pay their physician on a fee-for-service basis and are reimbursed by their insurer.

As in Canada, both the Sickness Funds and private insurers pay specialists on a fee-for-service basis. There are two fee schedules for specialists, one for services provided to Sickness Fund members and another for privately insured patients. Specialists who are employed by university hospitals and by psychiatric institutions are compensated on a salary basis. Pharmacists are paid on a fee-for-service basis by both public and private insurers.

3.5 Particularities

The most striking feature of the Dutch health care system is its reliance on private financing and delivery. Among the OECD countries, the Netherlands is second only to the United States in the share of private health care insurance, yet everyone has some form of insurance and user charges remain a relatively small fraction of the costs of health care (7% in 2000). It was not until the Second World War that the Dutch government became involved with health care on a major scale, and even then the long tradition of private ownership and provision of health services was never overturned, despite the introduction of extensive government regulation.

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[23] Akved & H.E.G.M. Hermans, "The Netherlands" in Medical Law – Suppl. (Deventer and Boston: Kluwer Law and Taxation Publishers, 1995) at 25.

[24] OECD, Health Policy Studies No. 2, The Reform of Health Care: A Comparative Analysis of Seven OECD Countries (Paris: OECD, 1992), p. 92.

[25] Colleen Flood, International Health Care Reform: A Legal, Economic and Political Analysis (London: Routledge, 2000), p. 107.

According to Colleen Flood, the health care system in the Netherlands is characterized, as in Canada, by a strong commitment to ensuring access to health care on the basis of need and not ability to pay. However, she also indicated that the Dutch are much more open to using the regulation of private insurance to attain this objective than exists in Canada. Thus, while the Dutch are committed to the progressive funding of health care, in the sense of having people contribute according to their means, they are not committed to public funding for its own sake.[26]

> ***We[the Netherlands] are the only country in the European Union that has private insurance for over 30 per cent of its population for acute health care. We had to start regulating that private health care sector about 15 years ago. The only reason it still works - and this is a personal opinion - is that we had heavy regulation for all bad health risks within the private market and as such the rest of the market was able to survive.***
>
> ***Dr. Hugo Hurts, Deputy Director, Health Insurance Division, Ministry of Health of the Netherlands (15:7)***

According to Professor Flood, the Dutch system for the provision of "normal" health care would appear to be susceptible to becoming a "two-tier system," the sort of system feared by many in Canada. However, she noted that two factors help prevent this from happening. First, those who purchase private health care insurance cannot fall back on the public system for some of their health care needs. Private insurers must cover <u>all</u> needs and not just skim off the easier kinds of care like elective surgery (as happens in the United Kingdom). Second, having private insurance does not enable Dutch citizens to jump queues in the public system. It is seen as against a physician's ethical code to prefer a patient with private insurance to other patients, and both kinds of patients are treated side-by-side in the same hospitals.

The health care system in the Netherlands has been the subject of many proposals for reform over the last 15 years. In 1987, the Dekker Commission, set up by the national government, released a report containing a full set of recommendations. Had these been fully implemented, they would have reduced the degree of government control and introduced more market-oriented elements, changing the Dutch health care system in two fundamental ways.

First, the Dekker Commission recommended that all health care insurers (both Sickness Funds and private insurers) be integrated and that a basic benefits package be defined. Under the proposed plan, consumers would continue to have a choice among competing insurance plans, but the distinction between Sickness Funds and private insurance would essentially disappear. Instead, every insurance plan would be obliged to offer at least a minimum degree of coverage specified in regulation by the national government. This was supposed to give consumers a wider range of choice, allowing them to select from amongst all the available health care insurance plans the one that offered the insurance features and premium levels that best corresponded to their individual situations.

Second, the Dekker Commission recommended that all health care insurers be given the freedom to contract with health care providers (general practitioners, specialists,

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[26] Colleen M. Flood, *Profile of Six Health Care Systems: Canada, Australia, the Netherlands, New Zealand, the United Kingdom and the US*, 30 April 2001, p. 13.

hospitals). The idea was that this would allow insurers to compete with one another in order to attract members based on the level and kind of care that their particular mix of providers was able to supply. The two new kinds of competition – amongst the insurers to attract members to their plans and among providers to obtain contracts with health care insurers – were to be introduced in the hope that this would help contain costs and lead to a more cost-effective health care delivery.

Only a limited number of the Dekker proposals were introduced between 1989 and 1993. In particular, the Sickness Funds were allowed to expand across the country and people who were insured by them were given the right to freely choose their insurer. As well, people insured under the Sickness Funds must now pay a nominal contribution, in addition to their income-related contribution. However, since 1994, successive national governments have decided to scrap further implementation of the Dekker reforms and to opt for gradual change within the existing system made up of three separate health care insurance schemes.

CHAPTER FOUR:

HEALTH CARE IN SWEDEN

4.1 Government Responsibility

Although Sweden has a unitary political system, it has, in practice, a high degree of decentralization – so much so that in many ways it resembles a federal system. As in Canada, health care in Sweden is a shared responsibility between the national and sub-national governments. In Sweden, these are the 26 county councils and 288 municipalities.

- The **national government** is responsible for public policy matters and legislation related to health care and health care insurance.[27] In addition, the national government transfers funds for the purpose of health care to the county councils and municipalities.
- The **county councils**[28] have full responsibility for the management and delivery of health care to their residents, subject to national legislation. This responsibility includes primary care, hospital care, prescription drugs, public health and preventive care. County councils provide most funding for health care through taxation applied within their boundaries.
- **Municipalities** are responsible for financing and operating home care and nursing homes for the elderly, the disabled and long term psychiatric patients. Like county councils, municipalities have the right to levy taxes on their population.

4.2 Health Care Insurance and Coverage

As in Canada, access to public health care insurance in Sweden is universal. However, in Sweden user charges are not seen as endangering access to publicly-funded health care and the county councils are free to require user charges, subject to certain limits established by the national government.

Public health care coverage in Sweden is considerably broader than in Canada, encompassing physicians, hospital services, drugs and dental care.[29] Long term care and

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[27] The most important national legislation is the Health and Medical Services Act of 1982 which establishes the division of jurisdiction between the national government and county councils. The Act also imposes certain restrictions that apply to both the delivery and financing of health care by county councils. The national legislation does not define basic or essential health care or drug package.

[28] County councils are independent regional government bodies whose members are elected every fourth year concurrently with national and municipal elections. As of today, there are 23 county councils; 3 large municipalities (Gotland, Gothenburg and Malmo) have chosen not to belong to any county council and therefore have the same health care responsibilities as the county councils.

[29] Long term care in nursing homes and home care are not managed or funded by county councils, but by municipalities.

home care are also publicly insured for specific groups of the population (the elderly, the disabled and long term psychiatric patients).

Contrary to Canada, private health care insurance that covers the same benefits as public insurance is legal in Sweden, but it is only used by a very small minority of the population.

> *[User] fees are somewhat higher in the hospitals [than in primary care centres]. This is because the aim is to make the patient choose a less expensive and acceptable level of care in the individual situation.*
> *(...)*
> *The idea of this different fees is that you should make a judgement as to whether you need a hospital or if you you can seek the service or the care at the local health centre instead.*
>
> *Lars Elinderson, Deputy Member, Swedish Parliament (19:6 and 19:7)*

4.3 Funding for Health Care

As in Canada, health care in Sweden is financed predominantly by the public sector through a combination of general taxation and social insurance (ie. employer/employee contributions). Taxes are levied at the national, county and municipal levels.[30]

The national government contributes to health care funding in two ways: through direct grants to the county councils (for physician and hospital services) and through the flow of funds from the broader social insurance system to designated health services delivered at both the county and municipal levels (doctors in private practice, prescription drugs, dental care, long term care and home care). The contribution by the national government to county councils is population-based, with certain additional adjustments to take account of the population's socio-economic status and other factors. This contribution represents about 10% of the county councils' total revenue. Funds from the national social insurance system are transferred to county councils and municipalities on a per capita basis.[31]

Most public resources that are used to pay for health care in Sweden are raised through income tax levied by the county councils. Each county council is free to set its own tax rate, at a level that is sufficient to cover its expenditures. The national government has, at times, imposed restrictions on the tax rates that county councils could levy. For example, during the late 1980s and early 1990s, the national government unilaterally froze the county council tax rates. Currently, the national government still exercises some control over the county council tax rate: those county councils that generate additional revenue by raising their tax rate suffer a reduction in the national government contribution equal to 50% of the additional revenue they raise themselves.

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[30] The national income tax is progressive (with a higher tax rate applying to higher taxable income). County councils and municipalities levy a proportional income tax (a flat rate on each person's taxable income). The base on which the county councils and municipalities levy their income tax is the basic national tax.

[31] The social insurance system is headed by the National Social Insurance Board, Rickforsakringsverket. The system is compulsory for all individuals over the age of 16 and is funded mainly by payroll contributions, with the remainder made up of national grants.

Municipalities are responsible for financing long term care and home care for specific groups of the Swedish population. They must reimburse county councils for nursing-home patients who have been hospitalized for acute care if these patients have been fully treated and could be discharged. The per diem fee level that municipalities must pay to county councils for these patients is set in regulations by the national government.

Private health care expenditures in Sweden are of two kinds: user charges paid by patients at the point of service and spending by private insurance companies. Spending by private health care insurance is minimal (only 2% of total health care expenditures), but user charges are more important. In contrast to Canada, user charges are required for publicly funded health services and they are levied on both physician and hospital services, as well as on drugs and dental care. Each county council determines its own user charge structure for out-patient care use.

Fees for in-patient care and prescription drugs are decided by the national government. The national government also specifies "stop-loss provisions" that limit the maximum amount any individual has to pay out-of-pocket for health services and drugs in any one-year period. Above this limit, there are no further user charges. Special provisions apply to persons with low income and persons under age 20 are exempt from user charges.

User charges required for hospital stays amount to about $12 per day, and fees for primary care consultation with nurses and doctors range between $15 to $20. The stop-loss provision set by the national government specifies that user charges for physician and hospital services per person cannot exceed $135 in a given year. For prescription drugs, patients must pay the first $135 per year and part of any additional cost up to a maximum of $270 per year (for a total of $405 annually).

In Sweden, user charges are regarded as "essential in order to make people choose the most economical service." In Sweden, user charges are not perceived as impeding access. Nor are they designed to raise money. In fact, the cost of administering the user charge scheme (collecting the fees and keeping track of how much an individuals has paid so that the cap is not exceeded) is almost as much as the total amount collected in user charges.

The Committee was told that the purchase of private health care insurance, although still limited to a small proportion of the Swedish population, is now growing at a fast rate due to waiting lists. This has resulted in the problem of queue jumping:

> *We have a very short tradition of private insurance in the health care system because the public health care system is supposed to cover everything for all individuals. Because of difficulties with accessibility, waiting lists and things like that, some people (...) have bought private insurance to have quick access to hospitals when they need it. (...) The growing rate of the number of insured, or people on private health care insurance, is some 80% or something like that now. It*

is growing very fast due to the normal waiting lists and the problems within the system today. [32]

4.4 Management and Provision

Responsibility for health care management and delivery rests primarily with the county councils. There are, however, national laws that oblige each county to offer all types of necessary care to all citizens, regardless or their ability to pay or where they live.

County councils own the local primary care centres, where patients are seen by doctors or nurses. Most doctors and nurses are salaried employees of the county council. Only a limited number of doctors (less than 10%) run a private practice. This contrasts to Canada where most doctors operate their own practice privately and are remunerated on a fee-for-service basis under the public health care insurance plan. Publicly employed doctors in Sweden are not allowed to practice privately on a part-time basis.

County councils in Sweden have the authority to negotiate the establishment of private physician practices and the number of patients they can see during a year.[33] Since the private physician must have an agreement with the county council in order to be reimbursed by public health care insurance, the county councils are able to regulate the private health care market. As a matter of fact, almost all doctors that practice privately on a full time basis do so within the public system. If the private physician has not signed an agreement with a county council, then the patient has to pay the full cost to the provider.[34]

The vast majority of hospitals are also owned by the county councils and their personnel, including doctors, are salaried employees of the county councils.[35] In comparison, most hospitals in Canada are private, not-for-profit organizations, and only a small minority of doctors are paid by salary. There are nine private hospitals in Sweden, most of them being located in the largest cities.[36] Public health care insurance does not reimburse patients for care received at these hospitals. It is only the well-to-do patients who can afford private hospital care.[37] According to Mr. Elinderson, Deputy Member of the Swedish Parliament, public hospitals are less productive and less efficient than privately-run hospitals:

We have a long tradition in Sweden of publicly run or operated facilities. Also, boards are populated by politicians, not professional doctors or lawyers and

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[32] Lars Elinderson (19:8).

[33] Funds to pay for private doctors are transferred to the county councils on a per capita basis by the national government through its social security insurance system.

[34] World Health Organization (WHO), Health Care Systems in Transition – Sweden. 1996, p.8.

[35] Depending of the county council, a patient may or may not need a referral in order to see a hospital-based specialist.

[36] "Swedish Health Care System Robust, Despite Regional Disparities," Ocular Surgery News – International Edition, May 1997.

[37] Margit Gennser, Sweden's Health Care System, The Fraser Institute, 1999.

other people who normally staff boards. I think that this has created a culture that is not very moderating for raising the productivity. That is the first point.

Second, the individual hospitals are not paid for performance. They have a fixed-budget system. All the staff, the medical professionals, are paid within the fixed salary system. This would not give any incentive for high productivity. These are two of the explanations. [38]

Overall, privatization of health service delivery has been very limited in Sweden. With the exception of general ancillary services, most health services are still provided by facilities owned by the county councils.[39]

In contrast to Canada, county councils in Sweden pay for all prescription drugs. Part of this payment is covered by a grant from the national government. All drugs prescribed by doctors and hospitals are purchased by a single national agency, *Apoteksbolaget*, a state-owned company which owns all community pharmacies and hospital pharmacies in Sweden. All pharmacists therefore are public employees. *Apoteksbolaget*, which operates its pharmacies under one-year contracts with the county councils, is required by national legislation to supply drugs at uniform prices throughout the country and at the lowest possible cost to both individual and society. Patients must defray the cost of their prescription drugs up to the maximum payable ($405). They then receive a card entitling them to free prescription drugs for the remainder of the year.

4.5 Particularities

In 1992, the national government introduced the "care guarantee" which established a maximum waiting time not exceeding three months for diagnostic tests, hearing aid tests and certain types of elective surgery (treatment for coronary artery disease, hip and knee replacements, cataract surgery, gallstone surgery, inguinal hernia surgery, surgery for prolapse and incontinence). Subsequently, maximum waiting time guarantees were introduced for consultations with primary care doctors (8 days) and specialists (3 months).

The national government provided the county councils with additional funding specifically intended to shorten waiting times. In some cases, the county councils distributed these funds only to those hospitals that were able to guarantee that patients would be treated within the specified period of time.

It appears that the care guarantee led to a substantial reduction in waiting times, to the point where waiting lists "ceased to be a political issue."[40] The care guarantee was abandoned when a new government was elected. This has resulted in a resurgence of long waiting lines.

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[38] Lars Elinderson (19:9).
[39] WHO, p. 13.
[40] Ake Blomqvist, International Health Care Models: Sweden, May 2001, p. 19.

The national government has also enacted legislation providing patients the right to freely choose the hospital in which they would receive treatment. Prior to that reform, patients requiring hospital treatment could only receive it in the hospital to which they were assigned, that is the hospital serving the area in which the patient resided. When a patient elects to receive care in a hospital other than the one to which he/she was originally assigned, a specified sum of money can be transferred from the budget of the latter to that of the former. County councils thus have to pay for services provided to their residents by another county council. The public at large have put considerable value on the increased freedom of choice this legislation offers. Many observers also claim it has produced a major change in the way patients scheduled for surgery are treated, as an incentive is created for each hospital to attract patients from other ones, or to prevent patients from going elsewhere.

> ***In Sweden, the 20 county councils (...) implemented internal market reforms throughout the 1990s by removing hospitals from county council control.***
> ***This arrangement frees health authorities from becoming bogged down with the minutiae of running facilities such as hospitals. Instead, they can focus on assessing the needs of their population and establishing contracts with various health care providers in line with their assessments of where the priorities lie. It also removes the perverse incentives of a system where health authorities pay they bills without being able to direct priorities, and are unable to reward efficient providers. The balance of power is realigned as at least one body takes a population perspective rather than having service provision driven by the existing bricks and mortar and the providers (mainly doctors) who work therein. With an internal market, health authorities hold the purse strings and choose between providers on the basis of quality and cost, rather than simply funding the decisions of those using the resources.***
>
> *Donaldson, Currie and Mitton, April 2001, pp. 7-8.*

In the 1990s, many county councils in Sweden embarked on an approach called the "purchaser-provider split." This split simply consists in separating the purchasing of health care from its provision. The goal is to improve efficiency in the publicly funded health care system through greater management by purchasers (the county councils) and greater competition among providers (hospitals, primary care centres, private doctors). Under such a scheme, the purchaser seeks to contract with or employ only those providers that are more likely to enhance cost-effectiveness and efficiency. The contract between the purchaser and the provider specifies what services that are to be rendered to what part of the population and how the provider will be paid. However, it does not specify how the services are to be provided. A fundamental principle of the purchaser/provider split is that the provider will only be paid the amounts specified in the contracts. Any deficits incurred should be the provider's responsibility or should result in some form of future sanctions. Purchasers are also free to choose among competing providers in contracting for their population's care. According to experts, the experience with the purchaser-provider split in Sweden has been mixed.[41]

With its 26 county councils, the health care system in Sweden is highly decentralized, but the national government plays a significant role in regulating health care at

[41] Blomqvist, p. 16.

the regional level. According to Professor Blomqvist, the division of responsibility for health care has not generated any major tension between the Swedish government and county councils.[42] He concludes that "a study of the interplay between the county councils and Sweden's national government may contain useful lessons in assessing the methods we use in Canada to regulate federal-provincial relations."[43]

[42] Blomqvist, p. 12.
[43] Blomqvist, p. 1.

CHAPTER FIVE:

HEALTH CARE IN THE UNITED KINGDOM

5.1 Government Responsibility

While it has the same Parliamentary system as Canada, the United Kingdom is a unitary state comprising Great Britain (England, Scotland and Wales) and Northern Ireland. Since 1999, however, there are National Assemblies in Scotland and Wales and the legislative assembly in Northern Ireland was also re-established as a consequence of the negotiations there between the concerned parties.[44] Even before devolution, each nation was responsible for managing its health care system, but the principles and functioning were basically the same throughout the United Kingdom.

The centralized nature of the United Kingdom state is reflected in the structure of its public health care system – the National Health Service (NHS). The NHS, which was established in 1948, still stands out as the most centrally managed and financed health care system in the world. The central government is not only involved in the financing of health services but is also heavily involved in the management and delivery of services. This contrasts sharply with Canada, Germany and Sweden where the responsibility for health care is shared between the different levels of government.

Responsibility for social care, such as long-term residential nursing care, is shared between local government, various social services departments and the NHS, which has led to long-standing problems of poor coordination.

5.2 Health Care Insurance and Coverage

As in Canada, all people normally resident in the United Kingdom are eligible for health care insurance coverage under the NHS. The NHS does not specify an explicit list of services to be covered. However, unlike Canadian Medicare, the NHS is more comprehensive as it covers physicians, hospitals, prescription drugs, dental care and optical services.

As in Canada, there are no user charges for physician services in the United Kingdom and hospital and specialist services are to be provided free-of-charge. However, user charges apply to prescription drugs, dental and optical services.

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[44] As part of the process of devolution, the Scottish and Welsh Assemblies are now responsible for health care, leading to some differences with the prevailing system in England. This chapter concentrates on the common history of the health care system in the United Kingdom as a whole, and on recent changes in England, unless otherwise specified.

In the case of drugs, there is a flat charge (£6 or about C$13.50[45]) for each prescription written on the NHS. However, about 60% of the population benefit from exemptions, and around 80% of prescriptions are written for people who are exempt. The Committee was told that, despite these exemptions, changes in the user charges can have a noticeable impact both on government revenue and on the number of prescriptions dispensed.

Within the NHS, general dental services are subject to a considerable amount of co-insurance, with individuals paying 80% of the cost of their treatment up to a maximum charge set at £348 (C$780) in 1999-2000. Here as well, certain groups, such as children, are exempt.

Unlike Canada, the United Kingdom does allow people to purchase private health care insurance that covers the same benefits as the NHS if these services are supplied by providers working outside of the NHS. Private insurance takes two main forms: employer-sponsored insurance (59% of the total) and individual insurance policies. In just under one third of the company schemes employees meet all or part of the premium costs. In 1996 there were 25 private health care insurers offering coverage in the United Kingdom. Seven of these were non-profit, provident insurers while the remaining 18 were commercial insurers. Two large insurers (PPP Healthcare and British United Provident Association [BUPA]) cover more than two thirds of those covered by private health care insurance. There is some degree of vertical integration in the private health care sector, as several of the large insurers are also amongst the major owners of the 230 medical/surgical hospitals that comprise the independent sector.

The proportion of people who purchase private health care insurance in the United Kingdom has historically been low, but has steadily grown in recent years to 11.5% of the population. Examination of the socio-economic status of people with private insurance indicates that it is heavily skewed towards higher socio-economic groups. The percentage of people with private insurance varies considerably across the country, approaching 20% in London, whereas in Scotland it is as low as 5%.

> ***In terms of jumping queues, yes it happens. One of the major reasons given by people who take private insurance is they want the peace of mind of being able to have elective operations for themselves or their families more quickly or at more convenient times than if they must depend on the National Health Service. That is seen, of course, as a cause of unfairness, which is one of the reasons that the government is committed to bringing down waiting times for National Health Service patients as rapidly as it can.***
>
> *Clive Smee, Chief Economic Advisor, Economic and Operational Research Division of the United Kingdom (20:35)*

The lines between public and private can be fuzzy, as private patients can be treated in an NHS facility (in what is called a "pay bed"[46]) as well as in private hospitals. Overall, surveys indicate that the most common reason people take out private health care insurance is to avoid waiting for elective surgery. The Committee was told that patients can begin their course of treatment in the private sector but end up in the NHS if

[45] The flat charge represented about 57% of the average prescription charge in 1998.

[46] There were an estimated 1400 dedicated pay beds in HNS private units in 1997, of which 39% were in London.

there are complications, if treatment beyond the scope of services that are available in the private sector is warranted, or if their insurance will not cover their treatment.

5.3 Financing for Health Care

In the United Kingdom, a larger proportion of health care spending is financed by the public sector (84%) than in Canada (70%). Like the public health care insurance scheme of Australia, the NHS is financed mainly through central government general taxation together with an element of national insurance contributions made by employers and employees. User charges account for less than 3% of total NHS financing.

The various waves of reform that swept across the health care system in the United Kingdome in the course of the 1990s have not significantly altered the ratio between public and private spending, as they have concentrated on introducing reforms within the publicly-funded system.

Because NHS spending dominates overall expenditures on health care in the United Kingdom, and because public spending is subject to tight cash limits, the level of spending on health care is the subject of intense political debate. One advantage that is often cited for the kind of centralized system that exists in the United Kingdom is that it permits a greater degree of overall cost control. This is illustrated by the fact that spending on health care in the United Kingdom in 1998 only represented 6.7% of GDP, compared to 9.5% for Canada, 10.6% for Germany and 13.6% for the United States.

5.4 Management and Provision

It is in the area of the management and provision of health services that many significant reforms of the health care system in the United Kingdom have been undertaken over the past decade. These reforms, which were established during the tenure of Prime Minister Margaret Thatcher, created an 'internal market,' meaning that certain market-oriented principles were introduced into the publicly-funded health care system. More precisely, the reforms referred to as the "purchaser-provider split" affected the relationships between the regional health authorities and the hospitals, while the establishment of "GP Fundholding" modified the organization and shape of general family practices. The Labour government of Tony Blair, elected in 1997, was critical of the internal market; it has since modified a number of significant features of the system, but has not sought to return it to its original form.

5.4.1 Hospital Services

Until 1990, NHS hospitals were state-owned and operated by the NHS through its regional health authorities. The budget of each regional health authority was determined by the central government by means of a weighted capitation formula based on the health care needs of the regional population. Each hospital's budget was then determined regionally through an administrative process involving negotiations between its management and the relevant regional health authority. Hospital specialists were salaried

employees of the NHS (but were also permitted to operate a private practice in parallel to the NHS).

A major critique of such a system was that regional health authorities were contracting, or purchasing, services on behalf of their local populations, but at the same time they were running the local hospitals. Thus, they had a pronounced conflict of interest aimed at protecting those hospitals.

In 1991, under the reforms of the Thatcher government, regional health authorities ceased to manage hospitals and became responsible, as purchasing organizations, for contracting with NHS hospitals and private providers to deliver the services required by their resident populations. Hospitals, for their part, were transformed into NHS Trusts; that is, not-for-profit organizations within the NHS but outside the control of the regional health authorities.

NHS trusts were expected to compete for contracts from health authorities and general practitioners for the provision of clinical services. Each trust was expected to generate income through service contracts with purchasers and had to meet centrally specified financial objectives such as making a 6% return on its capital assets. Payments to hospitals thus depended on the contract signed with the purchasers. Typically, contracts specified what services were to be provided and the terms on which they were to be supplied.

Despite its commitment to abolish the internal market, the Blair government has announced no plans to radically change the status of NHS Trusts. Trusts remain independent organizations within the NHS. However, their relationship with the regional health authorities has shifted from the previous emphasis on competition and financial performance toward a collaborative approach to quality of care.[47]

As in the past, hospital doctors remain directly employed by the NHS on a salaried basis. Their actual salary scales are determined by the government each year, taking into account the recommendations of the Review Body on Doctors' and Dentists' Remuneration. In addition to their NHS earnings, full-time NHS hospital specialists are permitted to earn up to 10% of their gross income from private practice.

5.4.2 Physician Services

When the NHS was established, general practitioners (family physicians) were allowed to operate as independent contractors within the NHS (like most family physicians currently practicing in Canada). They were also permitted the right to private practice alongside their NHS work. According to experts, the independent contractor status of general practitioners meant that "services had developed piecemeal and coordination with hospital based health services was poor."[48] For these reasons, the provision of care by general practitioners was brought into a "rostering system"; this system required patients to

[47] More precisely, the national government set up a regulatory agency, called the Commission for Health Improvement, the task of which is to visit every NHS institution – hospitals, health authorities, primary care groups – to monitor their activities.

[48] European Observatory, Health Care Systems in Transition – United Kingdom, 1999, p. 9.

register with one general practitioner, who then acted as a "gatekeeper" to the rest of the health care system. Patients could only be admitted to hospital, see a specialist or have their prescription drugs paid for if they had a referral from their general practitioner. Within such a system, individual general practitioners remained under contract with the NHS and were remunerated through a mixed system that combined a salary with capitation based simply on the number of patients on a doctor's list.

Then, with the 1991 reform, the concept of GP Fundholding was introduced. The purpose of this system was to give incentives to general practitioners to provide the most cost-effective form of care. Under the system of fundholdings, general practitioners were given a "fund" made of two spending categories: the cost of drugs they prescribed to their patients and the cost of certain kinds of specialist and hospital treatment for their patients. If, during a given period, the actual expenditures were less than the budgeted fund, the general practitioner was allowed to spend the surplus on improvements to his/her practice. Conversely, general practitioners who exceeded their budgeted fund faced a penalty corresponding to a portion of their deficit.

One criticism of the fundholding system was that it tended to produce inequality in the standard of care that different patients groups were receiving. More precisely, general practitioners in poorer regions had patients with greater health care needs than those practising in more affluent areas, making it harder for the former to generate a surplus. Another critique of the GP Fundholding was its very high administrative costs: general practitioners found that negotiating with hospitals and specialists for health services was both cumbersome and time consuming. In 1999, the Blair government reformed the GP Fundholding system by creating Primary Care Groups (PCGs). PCGs are group practices made of the merging of former GP Fundholders. Thus, PCGs are far larger than previous GP Fundholders, covering between 50,000 to 250,000 people in designated geographic areas. They are expected to develop through a number of stages until they are able to assume responsibility for commissioning care and for the provision of community health services for their population.

The various reforms enacted throughout the 1990s, such as GP Fundholding and more recently the creation of PCGs, did not affect the ways that general practitioners received their personal incomes. Fundholding budgets were for the purchase of hospital and community services and could not be used to supplement general practitioners' incomes. Currently, general practitioners are paid by the NHS as independent, self-employed professionals under a 'cost-plus' principle – the payments they receive cover their expenses in delivering services (the 'cost') and a net income for doing so (the 'plus'). The basic elements of the current payment system include:

- *Capitation fees* – annual fees payable for each patient registered on their list (with three levels of payment depending on the age of the patient). These amount to just over one half of general practitioners' gross income from all fees and allowances.
- *Allowances* – are the next largest element for the average general practitioner and include a basic practice allowance that covers the basic

costs incurred in setting up and maintaining a practice. The level of this allowance can vary in order to encourage practitioners to locate in underserviced areas.

- *Health promotion payments* – comprise payments for running health promotion and chronic disease management programs.
- *Item of service payments* – paid every time a general practitioner provides certain, usually preventive, services (e.g. contraception).

Overall, this combination of types of payment means that the income of individual general practitioners will depend on the number of patients on their list, the fees and allowances for which they qualify, the number and level of activities undertaken and the performance achieved.

5.5 Private Health Care Delivery

There are approximately 230 independent medical/surgical facilities and hospitals in the United Kingdom. In these private settings, doctors are paid fee-for-service either directly by the patient who may be then reimbursed by a private insurance company if he/she is a policyholder, or by the private hospital/clinic at which the services are provided. Private sector care is specialized and is mainly used for such elective (non-emergency) surgical procedures as hernias, varicose vein surgery and hip replacements. Abortions are the most common procedure (13.2% of the total). In recent years, there has been substantial growth in rather more complex procedures such as coronary bypass grafts and other heart operations.

> *The NHS has always made some use of privately run hospitals, but during the recent election campaign - this may be what you are referring to - the Blair government made a commitment to be pragmatic after the election as to whether private or public hospitals should be used to treat National Health Service patients. Those patients would be treated free at the point of use of those services, whether public or private. That is to try to bring down the waiting lists and waiting times, particularly for non-urgent medical treatments, and to help achieve the targets set by the government. That is quite a shift compared to, traditionally, how Labour governments have seen these issues. The Blair government claims to be new Labour, not old Labour, being much more pragmatic about where the care is provided, as long as it is free for the patients.*
>
> *Professor Chris Ham, University of Birmingham (20:27)*

By contrast, there is very little privately financed primary care in the United Kingdom. Only 3% of general practitioner consultations are estimated to be in the private sector. The main reason for the lack of development in this area is that general practitioners are not allowed to see patients on their NHS list privately or to issue NHS prescriptions and there are currently few insurance products to cover primary care services.

5.6 Particularities

As in Canada, all residents in the United Kingdom are covered through a universal, tax-financed health care insurance plan, the NHS. As in Canada, there are no user charges for hospital and physician services. However, coverage under the NHS is broader than in Canada, in the sense that prescription drugs and basic dental and vision care are included. User charges do apply to these additional publicly-insured services. By contrast to Canada, it is legal in the United Kingdom to purchase private insurance that covers the same kinds of services that are provided under the NHS.

From a Canadian perspective, two points stand out with regard to the unprecedented reform process undertaken in the United Kingdom over the past decade. In the first place, because of the relatively centralized nature of both the political system in the United Kingdom and of the health care system that was built in its image, it was possible to enact a 'big bang" reform that transformed key aspects of health care, probably forever.

In the second place, however, as Professor Julian LeGrand noted, "perhaps the most striking conclusion to arise from the evidence is how little overall measurable change there seems to have been" that can be attributed to the core mechanisms of the reforms designed to introduce elements of market-oriented competition into the publicly-funded system.[49]

> ***I would say "internal market" was always a bit of a misnomer in our case. I would say, it was a managed market and it turned out to be a heavily politically-managed market. (...) They did not actually implement the internal market as it was intended from the beginning, so in practice I would say there was not ever a great deal of competition between hospitals and other health care providers and to that extent the so-called internal market experiment was never tested in the way that was intended at the outset.***
>
> *Chris Ham, Director, Health Services Management Centre, United Kingdom (20:29)*

Why did the purchaser-provider split not function as originally envisaged? According to Ake Blomqvist the most likely explanation "was that there was a lack of incentive to make it work, on both sides of the market."[50] As he points out, on the provider side, hospitals that are already operating near capacity have little incentive to seek more patients, even if these will bring in greater revenues. On the purchaser side the health authorities were caught in a situation where they could have a major impact on individual hospitals if they shifted their purchasing elsewhere. They could have provoked layoffs and even closures, which would have destroyed relationships of trust that had been built up over many years and upon which the system still depended in order to function.

At the same time, however, it is important to note that the GP fundholding system quickly became more popular than anyone had anticipated. At the beginning of the 1990s it was seen as a small part of the overall reform process, but a variety of factors contributed to the unexpected growth of the scheme. There was evidence early on that fundholders could improve the services their patients received, and this created a bandwagon effect, with many physicians not wanting to be left behind. The Thatcher government

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[49] Le Grand, Julian, "Competition, Cooperation, or Control? Tales from the British National Health Service," Health Affairs, May-June 1999, p. 31.

[50] Blomqvist, Ake, Health Care Reform in Canada: Lessons from the U.K, Japan and Holland, unpublished paper, p. 44.

reinforced this trend by offering further benefits (e.g. computers) to GP fundholding practices that were not available to other doctors. Moreover, fundholding gave general practitioners a greater role in the overall health care system than they had previously. Hospital specialists have been forced to become more responsive and accountable to general practitioners who could now opt to take their business elsewhere.

However, experts are still divided over how to assess the overall balance sheet. Some feel that the "internal market" was never given a fair chance, that insufficient incentives were provided and too many constraints retained. Others argue that it is impossible to introduce a fully-functioning market system into a largely publicly-funded health care system. For the time being, the Blair government has opted for a system that attempts to engineer a shift towards greater cooperation amongst the various players, while retaining many aspects of the purchaser-provider split that was initiated under the previous Thatcher government.

CHAPTER SIX:

HEALTH CARE IN THE UNITED STATES

6.1 Government Responsibility[51]

The United States is a republic with a federal system of government consisting of a national (federal) government and fifty state governments. Each State and the national government have written constitutions that spell out what each government can and cannot do. While private insurance is the dominant player in the health care field, each level of government also plays a role with respect to health care:

- As in Canada, the **national government** of the United States provides health services to specific groups of the population, including military personnel, veterans with service-related disabilities, Native Americans (American Indians and Alaskan Natives), and inmates of federal prisons. More importantly, the US national government has the authority to raise taxes and appropriate funds for the purpose of the general welfare of the population, including health care.[52] Responsibility for administering the health care insurance programs Medicare and Medicaid and the recently enacted State Children's Health Insurance Program (SCHIP) is entrusted to the Health Care Financing Administration (HCFA) of the federal Department of Health and Human Services (DHHS). The federal government of the United States is also responsible for regulating health care insurance provided by employers and managed care organizations participating in federally subsidized health care.

- The responsibilities of **State governments** with respect to health care include the licensing of hospitals and health care personnel, public health (sanitation, water quality, etc.) and mental health. States can raise their own revenue by various types of taxes and there is no federal limit on their taxing powers. State governments must conform to federal regulations when receiving funds from the national government under Medicaid and SCHIP. State governments are also responsible for regulating private health care insurance, including managed care organizations, as well as Blue Cross/Blue Shield.

Although the federal and State governments of the United States do provide public coverage for health care, the American health care system remains unique around the world as it strongly relies on the private sector to both provide health care coverage and

[51] The information contained in this section has been mostly derived from M.W. Raffel and N.K. Raffel, "The Health System of the United States," in Health Care and Reform in Industrialized Countries, The Pennsylvania State University Press, 1997, pp. 263-289.

[52] This constitutional power has been interpreted as encompassing funding for health care delivery, health research and medical/nursing education.

deliver health services. This chapter focuses primarily on public health care insurance in the United States.

6.2 Health Care Insurance and Coverage

The national government of the United States is responsible for administering and operating Medicare, which provides health care insurance for the elderly. Jointly with the States, it finances Medicaid for the poor and the State Children's Health Insurance Program (SCHIP) for children.

6.2.1 Medicare

Medicare is a federal health care insurance plan for people 65 years of age and over, some people with disabilities under 65, and people with end-stage renal disease. Medicare is not means-tested and has two parts:

- *Part A* provides coverage for hospital services, skilled nursing facility care for the purpose of rehabilitation, hospice care, and some home care.[53] Most people get *Part A* automatically when they turn age 65.[54] They do not have to pay a monthly payment or premium to be entitled to *Part A* Medicare benefits. People, however, must pay user charges. For 2001 each beneficiary must pay a deductible of $792US. With respect to skilled nursing facility care, *Part A* pays all charges for the first 20 days, then a co-insurance requirement kicks in for days 21 through 100. All costs beyond the 100th day must be paid by the patient. A 20% coinsurance payment also applies to medical equipment (such as wheelchair or walker) for home care. People who select hospice care must pay some of the costs for drugs and inpatient respite care. People with low income may have their Medicare costs (user charges) paid by the State under Medicaid (described below).

- *Part B* covers physician services, outpatient hospital care (including emergency room visits), ambulance transportation, diagnostic tests, laboratory services, some preventive care (such as mammography and Pap smear screening), services of physical and occupational therapists, and some home care for which *Part A* does not pay. *Part B* does not cover prescription drugs, routine physical examination, dental care, cosmetic surgery, hearing aids, vision care. Enrolment in *Part B* is optional. People must pay a monthly premium ($50US in 2001) if they

[53] Hospital care includes semi-private rooms and meals, general nursing services, operating and recovery room costs, intensive care, drugs, laboratory tests, X-rays, and all other necessary medical services and supplies (up to 90 days for each benefit period). Coverage for skilled nursing facility care is mainly for the purpose of rehabilitation and includes semi-private room and meals, skilled nursing services, rehabilitation services, drugs, and medical supplies (up to 100 days for each benefit period). Home care only refers to part-time or intermittent nursing services prescribed by a physician for treatment or rehabilitation services, and it does not include custodial services (help with daily living activities like bathing, eating or getting dressed).

[54] Coverage for Part A may be purchased by individuals who do not have insured status through the payment of monthly premiums.

enrol before they turn 65. The monthly premium is higher for people who sign up at a later stage (and they then pay this higher premium for the rest of their life). *Part B* pays 80% of the cost of insured services. In addition to covering the remaining 20% (coinsurance) people must also pay a deductible of $100US per year. People with low income may have their premium paid by the State where they reside (under Medicaid).

Medicare is delivered through two different mechanisms. First, under the original Medicare plan, the federal government contracts with private insurance companies (there are about 55 of them) to process and pay claims. Many of these insurers offer their clients "Medigap," a supplemental insurance policy that helps to fill the gaps in the plan (coinsurance, deductibles and other out-of-pocket costs). Some Medigap policies will also cover services not covered by Medicare, such as prescription drugs. Some 80% of Medicare beneficiaries are enrolled in the original plan.

Second, since 1997, Medicare can be provided through "Medicare+Choice." This option offers access to managed care plans – such as Health Maintenance Organizations (HMOs), and Preferred Provider Organizations (PPOs) – as well as to medical savings accounts, or other private health care insurance options.[55] Medicare managed care plans have the following characteristics:

- They must provide all of the services that are offered under the original Medicare plan;
- They can offer a variety of additional benefits, like preventive care, prescription drugs, dental care, hearing aids, eyeglasses and other items not covered by the original Medicare plan. Costs for these extra benefits vary greatly among plans.
- They usually impose restrictions on the choice of providers. For example, clients enrolled in an HMO will only be able to seek care from doctors and hospitals employed or owned by the HMO.
- Given these restrictions on the freedom to choose, these plans permit savings in comparison to the average cost of the original Medicare coverage. Those who enroll in the HMO option are charged a lower premium to belong to Medicare *Part B*.

6.2.2 Medicaid and SCHIP

Medicaid is a joint federal and State health care insurance plan available to people with low income. It is means-tested, but low income is only one of the criteria for Medicaid eligibility. Assets and resources can also be tested against established thresholds. Basic coverage includes physicians, hospitals, laboratory and x-ray services, etc. The federal government pays half of the cost incurred by individual States in providing coverage for the

[55] An HMO is an organization that offers health services provided by selected doctors and hospitals. In exchange for a monthly fee, enrolees receive care as needed. PPOs are a simplified form of HMOs in the sense that they provide incentives to their enrolees to use a limited number of selected providers at a reduced cost. Medical savings accounts are currently being offered on a trial basis.

poor and establishes broad national guidelines. However, each State 1) administers its own program; 2) establishes its own eligibility standards; 3) determines the type, amount, duration and scope of services, and 4) sets the rate of payment for services. Medicaid programs therefore vary from State to State.

Medicaid does not make health care coverage available to all people who can be considered poor. Coverage is provided to those considered either "categorically needy" or "medically needy." The categorically needy population includes persons receiving federally assisted income maintenance payments (mostly children, the aged, the blind and disabled). The medically needy population includes those in the welfare category who do not receive federal cash assistance but whose net income falls below State standards. Most States have additional state-only programs to provide medical assistance for specified poor persons who do not qualify for the Medicaid program, but no federal funds are provided for state-only programs. States may require user charges from some Medicaid recipients for certain services. User charges, however, are not required for emergency services, pregnant women and children under age 18.

SCHIP is a program initiated in 1997 by the federal government to expand public health care coverage to otherwise uninsured children. Under this program, each State receives enhanced federal matching payments up to a fixed allotment. SCHIP may be provided either as an expansion of Medicaid, or through separate State programs. It enables States to provide coverage to children from working families with income too high to qualify for Medicaid but too low to afford private health care insurance.

Like Medicare, Medicaid is provided through various payment arrangements to eligible beneficiaries.

6.2.3 Public and Private Health Care Coverage

Overall, public health care insurance covers about 24% of the population in the United States. Private insurance, either purchased directly or obtained through employment, is predominant in the health care field. The majority of Americans with private insurance receive coverage through an employer-sponsored plan.

> ***The U.S. is unique in the source of health insurance, as employer health insurance is the dominant form of health insurance coverage in the United States. (...) Health insurance, in a way, is part of a total compensation package for workers. (...) 63 per cent of those who are covered get their coverage through employer- sponsored programs.***
>
> *Christine Schmidt, U.S Department of Health and Human Services (23:5)*

American employers may provide their employees with self-insurance plans or insurance plans contracted out with third-party insurers. Self-insured employers usually operate and administer their own plans; a few of them even run their own health care facilities. In addition to commercial plans, third-party insurers include HMOs and PPOs, which both insure and deliver health services. It is recognized that HMOs, PPOs and employer-sponsored plans somewhat restrict patient's choice among health care providers. Individuals who do not have access to

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employer-based coverage may obtain health care insurance by purchasing it directly from commercial insurers or HMOs.

A report by Health Canada points out that, although employer-sponsored insurance is voluntary (except in Hawaii), it is nonetheless encouraged by tax policy. As in Canada, employer-paid contributions to employee health care costs in the United States are deducted from the employer's taxable income and are, in the end, basically a substitute for cash wages.[56]

Despite the availability of public and private health care insurance, it is estimated that some 43 million Americans, or 15.5% of the population, have no coverage at all (see table below). Moreover, a significant proportion of Americans remain underinsured (that is they have some coverage but there is no limit on out-of-pocket costs).

TYPE OF HEALTH CARE INSURANCE AND COVERAGE STATUS IN THE UNITED STATES, 1999

	NUMBER OF PERSONS ('000)	PERCENT OF POPULATION (%)
Private	194,599	71.0
Employment-based	172,023	62.8
Government	66,176	24.1
Medicare	36,066	13.2
Medicaid	27,890	10.2
Military	8,530	3.1
Total Covered	231,533	84.5
Not Covered	42,554	15.5
Total	**274,087**	**100.0**

Note: The estimates by type of coverage are not mutually exclusive: people can be covered by more than one type of health care insurance.

Source: US Census Bureau and Library of Parliament.

[56] Health Policy and Communications Branch, International Affairs Directorate (Health Canada), US Health Care System, 15 January 2001.

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[7] Health Policy and Communications Branch, International Affairs Directorate, Health Canada, US Health Care System, 15 January 2001.

6.3 Funding for Health Care

In the United States, health care is financed predominantly by private sources (55%), with the balance (45%) coming from public sources. Private spending includes private health care insurance (33%), out-of-pocket payments made by individuals under both public and private plans (17%), and other sources (5%). The federal government contributes approximately 33% of total health care spending, with State and local governments paying the remaining 12%.

Medicare *Part A* is financed primarily from the social security payroll tax: contributions are mandatory and are set at 1.45% for employers and 1.45% for employees. Medicare *Part B* is financed by a combination of premiums and general tax revenue (from both federal and State governments). As indicated above, Medicare funding is also derived from a variety of user charges.

The portion of the Medicaid program that is paid by the federal government is derived from general revenue. The federal share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually for each State according to a formula that compares the State's average per capita income level with the national average. By law, the FMAP cannot be lower than 50% or greater than 83%. Wealthier States have a smaller share of their costs reimbursed. The federal government also shares in the State's expenditures for administration of the Medicaid program, covering 50% of most administrative costs for all States.

6.4 Management and Provision

As in Canada, most physicians in the United States practice privately. Under Medicare, payments for physician services are made on a fee-for-service basis. However, since 1997, with the advent of managed care organizations, other methods of remuneration, such as capitation, are becoming more popular.

Under Medicaid, payments are made directly to physicians. Each State has relatively broad discretion in determining its method of reimbursement. These include paying physicians on a fee-for-service basis and the use of various prepayment arrangements, such as the capitation system used by HMOs. Physicians participating in Medicaid must accept the Medicaid reimbursement level as payment in full; that is, no extra-billing is allowed.

According to Colleen Flood, about 15% of hospitals in the United States are private for-profit institutions, 60% are private non-profit, and the remaining 25% are owned by States or local governments.[57] Under Medicare, hospital-based specialists are remunerated on a fee-for-service scheme.

Medicare reimburses hospital services according to a system of "Diagnosis Related Groups" (DRGs). This system is based on a list of some 500 services, each of

[57] Colleen Flood, Profiles of Six Health Care Systems, 30 April 2001, pp. 3-5.

which is assigned an average national cost. When admitted, patients are classified into one of the 500 categories. At the end of the treatment episode, the hospital receives the amount shown on the list. It does not depend on the length of stay, or the volume of services actually provided. The DRG system is intended to encourage efficiency by rewarding those hospitals that can treat patients at a lower than average cost. Some States also use this method to fund hospitals delivering Medicaid services.

6.5 Particularities

Unlike Canada, the United States does not have a public system of health care insurance that offers coverage to all its citizens. However, its Medicare system does offer universal coverage for all Americans over age 65 and its Medicaid program does guarantee health care coverage to a definite group of the population, particularly those with low incomes.

In the 1990s, during the debate about constructing a system of universal health care insurance plan in the United States, one proposal put forward was to adopt the Canadian system. Another quite different proposal was that universal coverage could be accomplished simply by expanding Medicare to cover every American. In many ways, these two proposals are relatively similar. As in the Canadian system, conventional Medicare gives patients unrestricted choice among providers, and doctors – both general practitioners and specialists – are paid on the basis of a regulated fee for service schedule.

There are, however, significant differences. One is that there are some user charges in American Medicare, and the possibility exists for those individuals who so desire to hold supplementary private health care insurance which covers all or part of these user charges. Another difference is that under American Medicare, patients do have the choice between the conventional public plan and the HMO option, and, in addition, they have some degree of financial incentive to choose the latter, which is less costly to the plan. Finally, a very important difference is in the way hospitals are funded, with the Americans using the DRG system.

Overall, there is widespread agreement in Canada among both health care experts and the general public that, on the whole, the Canadian health care system is vastly superior to the American system. A large proportion of the population in the United States has no health care coverage at all and a great number of Americans remain clearly under-insured.

CHAPTER SEVEN:

MEDICAL SAVINGS ACCOUNTS (MSAS)

A number of proposals for Medical Savings Accounts (MSAs) have been put forward in recent years in Canada.[58] MSAs are health care accounts, similar to bank accounts, set up to pay for the health care expenses of an individual (or family). They are often established in conjunction with high-deductible (or catastrophic) health care insurance. Money contributed to an MSA belongs to, and is controlled by, the account holder, accumulates on a tax-free basis and is not taxed if used for health care purposes.

MSAs usually involve three levels of payment. First, money in the account is used for normal medical expenses. Next, if the account is exhausted and the deductible has not been reached, the expenses are paid out of pocket. Third, the insurance policy covers expenses beyond the deductible.

The general theory is that consumers would make more judicious and cost-effective decisions if they were spending their own money, rather than relying on the public purse. There are several different ways of structuring these accounts. MSA systems have been operating in a few countries. This chapter briefly examines the operation of MSAs in Singapore, South Africa and the United States and reviews the proposal for MSAs put forward in Hong Kong.[59]

7.1 MSAs in Singapore

The Singapore government's philosophy of health care delivery can be summed up in the following words – individual responsibility coexisting with government subsidies to keep health care affordable. An overview of the Singapore health care system describes the system this way:

> *Patients are expected to pay part of the cost of medical services which they use, and pay more when they demand a higher level of services. The principle of co-payment applies even to the most heavily subsidized wards to avoid the pitfalls of providing "free" medical services.*[60]

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[58] See the following documents: 1) William McArthur, Cynthia Ramsay and Michael Walker ed., Healthy Incentives: Canadian Health Reform in a Canadian Context, The Fraser Institute, 1996; 2) Cynthia Ramsay, "Medical Savings Accounts", Critical Issues Bulletin, The Fraser Institute, 1998; 3) David Gratzer, Code Blue – Reviving Canada's Health Care System, ECW Press, 1999; 4) Dennis Owens and Peter Holle, Universal Medical Savings Accounts, Frontier Centre for Public Policy, Policy Series No. 5, July 2000.

[59] This chapter is a summary of a more exhaustive paper on MSAs prepared by Margaret Smith from the Parliamentary Research Branch, Library of Parliament. Her paper is available on the Committee's Website.

[60] Ministry of Health, Singapore, Overview of the Singapore Healthcare System, February 2001, http://www.gov.sg/moh/mohinfo/mohinfo_a.html

Therefore, health care financing in Singapore is a combination of public and private sources encompassing general tax revenue, employer/employee contributions, compulsory savings, private insurance and out-of-pocket payments. [61] Because individual responsibility for health care expenses is one of the tenets of the Singapore health care system, the government has made saving money for health care expenses compulsory. There are currently three government programs that operate to assist individuals in this regard:

- **Medisave** is a compulsory savings program for certain health care expenses. Under this program, which was established in 1984, every employee is required to contribute a certain percentage of his/her income, with a matching contribution from the employer. These contributions are collected in a central fund managed by the national government. There is an upper limit on the total contributions to Medisave. According to the Ministry of Health of Singapore, the limit is imposed "to prevent an excessive build-up of Medisave balance which could result in unnecessary use of medical services." [62] Medisave accounts can be used to pay for hospital and certain other medical expenses for the individual account holder and his or her family. Withdrawals from Medisave are subject to limits that require some cash co-payment from patients, particularly those who choose private hospitals or more expensive ward accommodation in public hospitals. Medisave also covers certain expensive outpatient treatments such as, radiotherapy, chemotherapy, renal dialysis and HIV anti-retroviral drugs. Subject to a requirement to maintain a balance, account holders are permitted to withdraw their Medisave accounts at age 55. In addition, any remaining Medisave balance can be transferred as part of the account holder's estate on death.

- **MediShield** is a non-compulsory, low-cost catastrophic illness insurance scheme designed to cover medical expenses from major and prolonged illnesses. It was introduced in 1990 as a supplement to Medisave. Medisave account holders under 75 years of age are eligible to participate in the MediShield scheme. MediShield premiums are paid from Medisave contributions. Premiums vary depending on age. MediShield covers most hospital expenses including intensive care, surgical operations and implants. It also covers outpatient kidney dialysis, outpatient chemotherapy, radiotherapy for cancer treatment and certain drugs for transplant patients and pre-dialysis and dialysis patients. Patients are required to pay user charges under MediShield, subject to an annual threshold. [63]

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[61] Information about the Medisave program comes from a document prepared by the Ministry of Health, Singapore, Health Care Financing in Singapore, June 2000. Available on the Internet at http://www.gov.sg/moh/mohinfo/mohinfo_b.html.

[62] Health Care Financing in Singapore, June 2000.

[63] Much of the information about MediShield comes from Singapore Ministry of Health at http://www.gov.sg/moh/mohinfo/mohinfo_b(B).html.

- **Medifund** is a government endowment fund that operates as a safety net to help the poor and needy pay for hospital care. At the time the fund was created, the government made an initial capital injection which has then been followed by other capital injections. The interest income (but not capital) from the fund is distributed on a case-by-case basis to public sector hospitals.

A 1996 study prepared for the American-based National Center for Policy Analysis on the Singapore experience with MSAs stated that the Singapore program provides incentives "to reduce consumption and offer protection against extraordinary events and free-rider abuses." [64] Because individuals must start saving at an early age, savings accumulate to cover costs later in life when medical care needs will be greater. The study concluded that Medisave and MediShield have worked well as part of a system that balances personal savings for medical care and government management of the health care system that has kept overall costs relatively low. [65] Another study, however, mentioned in a recent C. D. Howe Institute Commentary (April 2001) reports that hospitals in Singapore did not begin to compete on price and the per capita cost of health care rose faster after the introduction of the health care model that included MSAs than it had prior to that time. [66]

7.2 MSAs in South Africa

The private health care insurance market in South Africa offers a wide range of insurance plans to residents that elect to be treated in private facilities. Since their introduction in 1994, MSAs have grown to half of the private insurance market. [67]

In South Africa, MSAs allow individuals to do essentially two things: (1) to pay for medical expenses that are covered by insurance but are less than the deductible amount specified in their medical insurance policies; and (2) to pay for certain types of heath care that are not covered by insurance (for example, corrective eye surgery). MSAs are set up as insurance plans that typically have the following features:

- first dollar coverage for non-discretionary services, such as heart bypass operations and other inpatient hospital services;
- a deductible of about $1,200 for discretionary expenses, such as visits to a doctor and other outpatient services;
- first-dollar coverage for medications required to treat certain chronic conditions. [68]

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[64] Thomas A. Massaro and Yu-Ning Wong, *Medical Savings Accounts: The Singapore Experience*, NCPA Policy Report No. 203, April 1996, p. 2. Document available on the Internet at http://www.ncpa.org/studies/s203/s203.html.

[65] *Ibid.*, pp. 11-12.

[66] Cam Donaldson, Gillian Currie, Craig Mitton, C.D. Howe Institute Commentary, *Integrating Canada's Dis-Integrated Health Care System, Lessons from Abroad*, No. 151, April 2001, p. 18 (see www.cdhowe.org).

[67] Much of the information on Medical Savings Accounts in South Africa comes from a policy report entitled, *Medical Savings Accounts in South Africa*, prepared by Shaun Matisonn for the U. S.-based National Center for Policy Analysis, NCPA Policy Report No. 234, June 2000. (See http://www.ncpa.org/studies/s234/s234.html).

MSA contributions are given favourable tax treatment. Two-thirds of any employer contribution to an MSA for employees is excluded from the employee's taxable income and two-thirds of employee contributions can be made with pre-tax dollars.[69]

For the most part, there is a considerable amount of flexibility in the various MSA plans offered in South Africa. There would appear to be few limits on the amount that an individual can contribute to his or her MSA to cover expenses below the insurance deductible. An individual, an employer or both can make MSA contributions and unspent balances in an account can be distributed back to the account holder annually.[70]

A study prepared for the National Center for Policy Analysis (NCPA), a long-time proponent of MSAs, concluded that the South African experience with MSAs has been a positive one. MSAs have become a popular health care vehicle due in no small part to a flexible regulatory environment that allows insurers to tailor plans to the needs of the private market and offer incentives to encourage a healthy lifestyle and wellness.[71] More precisely, the study reported that:

- MSAs save money – on average MSA holders spend about half as much on outpatient services plus drugs as do people in traditional plans.
- there is no evidence that MSA holders substituted care with no deductible for care with a high deductible.
- similarly, there is no evidence that MSA holders forgo appropriate care – a comparison of catastrophic claims under MSA and traditional plans did not reveal a higher level of such claims by MSA holders.
- although MSA plans appeal to people who are healthy, MSA plans can be attractive to those who are sick and have high health care costs.[72]

7.3 MSAs in the United States

Much of the discussion and literature and most of the controversy and debate relating to MSAs originates in the United States where, in the wake of rising health care costs and increasing criticism of the system of managed care by HMOs and other providers, MSAs have been proposed as means of reducing health care spending and empowering health care consumers.

MSAs are authorized favourable tax treatment under both federal and State legislation. MSAs are currently offered by employer-sponsored insurance plans as well as under the Medicare Plus Choice.

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[68] *Ibid.*, p. 9.
[69] *Ibid.*, p. 10.
[70] *Ibid.*
[71] For example, the Policy Report notes that one plan offers a point system for having preventative tests such as pap smears and mammograms and participating in an exercise program. Accumulated points can be redeemed for benefits such as airline tickets.
[72] *Ibid.*, p. 15-17.

7.3.1 Private Sector MSAs

The first federal program in the United States to authorize favourable tax treatment for MSAs became effective on January 1, 1997. The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) established a four-year medical savings account demonstration project ending in 2000 and set out the requirements for the tax treatment of MSAs at the federal level. The demonstration project has since been extended for two additional years.

The federal MSA demonstration is limited to 750,000 MSA account holders.[73] Those eligible to participate in the federal MSA program include self-employed individuals and businesses with 50 or fewer employees. (Unlike the federal MSA scheme, state MSA programs do not cap the number of employees.) While employers with more than 50 employees are restricted from offering the federal MSA tax benefit to employees, they can still offer MSA-style programs, although with limited tax benefits.

In order to participate in the program, participants must have a qualified high-deductible (catastrophic) health insurance plan to cover large health care expenses. A high deductible health plan is a comprehensive health insurance plan with a higher annual deductible than typical health plans and a maximum limit on annual out-of-pocket medical expenses. For individuals, the deductible must be between $1,550 and $2,350 (with a total out-of-pocket maximum of $3,100), and for families, the deductible must fall between $3,100 and $4,650 (with a total out-of-pocket maximum of $5,700.) The MSA is set up through a trustee who can be a bank, insurance company or any other entity approved by the Internal Revenue Service.

Contributions to an MSA can be made by the employer or the employee, but not by both during the same year. For individuals, contributions up to 65 percent and for families up to 75 percent of the annual health plan deductible can be contributed. There are also upper limits on contributions based upon the individual's wages or compensation. The MSA is portable; it is owned by the account holder and follows the account holder when the person changes jobs.

MSAs offer a number of tax advantages. Employer deposits into an MSA plan are not classified as taxable benefits for employees, employee contributions qualify for a tax deduction and funds accumulate in the MSA tax-free. Contributions in excess of annual limits, however, are subject to a 6% excise tax. MSA funds are typically used for routine health care expenses. Withdrawals from MSA plans are tax free if used for medical expenses that would qualify as a medical deduction for income tax purposes. Non-medical spending from an MSA is subject to taxation and additional tax penalties. Money remaining in the MSA account at the end of the year can be rolled over to the next year without penalty.

A beneficiary can be designated for an MSA account. If a spouse is designated, on death the account is treated as the spouse's plan. If someone other than the spouse is designated, on death the account loses its MSA status and its fair market value is taxable to

[73] Internal Revenue Service, Publication 969 gives a detailed a description of the requirements for federal medical savings accounts. This publication is the source of the information about the federal MSA program. (http://www.irs.ustreas.gov/prod/forms_pubs/pubs/p969.htm).

the designated beneficiary. Where there is no designated beneficiary, the fair market value of the plan is included in the deceased's final income tax return.

The proponents of the 1997 legislation thought that insurers would be quick to enter the MSA market and many individuals would opt for MSAs. However, the market has developed slowly with some 100,000 MSAs having been set up.[74]

A report to Congress by the Medicare Payment Advisory Commission (MedPac) on Medical Savings Accounts in the context of Medicare (November 2000) cited four main reasons for the slow development of MSAs.[75] These are: limited supply, lack of broker interest, limited demand and program design problems.

- *Limited Supply*: The federal law establishing MSAs limited eligibility to self-employed people and those employed in firms with 50 or fewer employees. According to the MedPac report, these eligibility requirements had the effect of limiting suppliers of MSAs to insurance companies that participate in or want to enter the individual and small group insurance markets. Ccompanies entered the MSA market to have a market presence should the plans become popular but many did not enthusiastically pursue MSAs when they found that the level of interest in the plans was low. Insurers were also reluctant to enter the market because MSAs were established as a four-year demonstration project.[76] Similarly, a United States General Accounting Office (GAO) Report to Congressional Committees on MSAs (December 1998) found that while a wide range of insurers were offering MSA plans, only a minority of them were marketing them aggressively.[77]

- *Lack of broker interest*: The MedPac report points out that agents have not displayed a great deal of interest in selling MSAs. Because MSA policies tend to have lower premiums than other policies, agents receive lower commissions for sales. Furthermore, the public's lack of familiarity with MSAs and the somewhat complicated nature of the accounts required agents to devote a considerable amount of time to selling the product. As a result, agents have been reluctant to commit the time necessary to learn about and sell the product.[78]

- *Limited demand*: The MedPac report points out that self-employed individuals could constitute a potentially large market for MSAs. Many of the self-employed, though, continue to prefer the certainty of traditional

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[74] Linda Klinger, "Few Takers for Medical Savings Accounts, Washington Business Journal, April 2, 2001. (http://washington.bcentral.com/washington/stories/2001/04.02/focus4.html).

[75] Medicare Payment Advisory Commission (MedPac), Report to Congress, Medical Savings Accounts and the Medicare Program, November 2000, pp. 6-7 (http://www.medpac.gov/).

[76] *Ibid.*, p. 6.

[77] United States General Accounting Office (GAO), Report to Congressional Committees, Medical Savings Accounts Results from Surveys of Insurers, December 1998, GAO/HEHS-99-34. p. 11 (http://www.gao.gov/archive/1999/he99034.pdf).

[78] MedPac, Medical Savings Accounts and the Medicare Program, p. 6.

comprehensive medical insurance plans with relatively low deductibles.[79] The GAO report confirmed that sales were lower than expected. Some insurers participating in the GAO survey felt that the low sales numbers were not surprising in light of the complexity of the MSA product and the limitations of the demonstration project.[80]

- *Program design problems*: The MedPac report also notes that the restrictions applying to federal MSAs have impeded their growth. These restrictions, which were put in place in part to allay concerns about possible negative effects on tax revenues and the health insurance market if MSAs were taken up in large numbers by healthy and relatively wealthy individuals, have had a dampening effect on the MSA market. Consequently, the number of policies was limited to 750,000 and no new policies could be issued after December 31, 2000, minimum and maximum deductibles were established, a limit on out-of-pocket amounts was imposed, the amount that could be contributed to an MSA was set at between 65 percent and 75 percent of the deductible, and only the employee or the employer could contribute to the account, but not both.[81]

A 1998 Policy Report by the National Center for Policy Analysis looked at obstacles to the growth of the U.S. MSA market.[82] Among other things, the NCPA suggested that the range of permitted deductibles was too narrow and the limit on the amount that could be deposited to an MSA account could expose MSA holders to substantial out-of-pocket health care expenses before their insurance took over. Concluding that the MSA legislation was "the result of a number of political compromises that had little to do with health policy, economic research or market demand",[83] the NCPA made a number of recommendations for MSA reform, including the following:

- allowing a wider range of deductibles to give insurers more flexibility to design MSAs to meet consumer needs;
- allowing the market to determine the out-of-pocket exposure under MSA plans;
- permitting employer and employee contributions to MSA plans; and
- removing the enrollment cap of 750,000.[84]

7.3.2 Medicare Plus Choice

The Medicare+Choice MSA plan combines a high deductible health insurance plan (in the order of $6,000) and a medical savings account. Under this program, Medicare pays the insurance premium, which because of the high deductible is lower than a typical

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[79] *Ibid.*, p. 7.
[80] GAO, Medical Savings Accounts Results from Surveys of Insurers, p. 12.
[81] MedPac, Medical Savings Accounts and the Medicare Program, p. 7.
[82] National Center for Policy Analysis, Medical Savings Accounts: Obstacles to Their Growth and Ways to Improve Them, NCPA Policy Report No. 216, July 1998. (http://www.ncpa.org/studies/s216.html).
[83] *Ibid.*
[84] *Ibid.*, pp. 2-4.

health insurance premium, and deposits the difference between the cost of the premium and the normal Medicare capitation amount in an MSA. Plan contributions are the same for all beneficiaries but payments are adjusted for demographic and health status.

The Medicare+Choice MSA was intended to give Medicare beneficiaries more control over their health care by allowing them to choose their health care providers under financial arrangements that they would negotiate. One benefit it was hoped that this approach would achieve was reduced spending on discretionary health care as beneficiaries became more conscious of the costs involved.

Under the program, only the Medicare authority is permitted to make deposits to MSAs; Medicare beneficiaries cannot contribute to the account. Deposits and interest earned are free of federal income tax and qualified spending from the account is tax-free. Beneficiaries who do not have major health expenses can take the MSA payment as additional income over time. The savings account can be used for medical expenses that qualify for income tax deductions and for payment of certain insurance premiums such as long-term care. If the amount in the account accumulates to more than 60 percent of the annual deductible level, the amounts above 60 percent can be withdrawn penalty-free for any purpose (although these amounts would be treated as taxable income). On death, the MSA can be transferred to a spouse who is designated as a beneficiary and will be treated as the spouse's MSA. Otherwise, the MSA loses its MSA status and the fair market value becomes taxable.

As of November 2000, no organization had applied to offer an MSA plan to beneficiaries under Medicare+Choice. Consequently, Congress asked the Medicare Payment Advisory Commission (MedPac) to report on how the program could be changed to make it a viable option for organizations and Medicare beneficiaries.

MedPac's November 2000 report, *Medical Savings Accounts and the Medicare Program*, concluded that the private sector would not offer Medicare MSAs for two reasons:

1. little demand from the risk-averse Medicare beneficiary population, and

2. the expense and difficulty of marketing a complex product such as Medicare MSAs to a fragmented and scarce set of customers. [85]

MedPac noted that as premiums under the traditional Medicare plan are relatively low and plan coverage is broad there is little incentive for Medicare beneficiaries to move to MSAs. While MedPac observed that some of the conditions applying to the program that discouraged participation could be changed, it concluded that institutional changes would probably not encourage much participation because of the underlying market characteristics. In addition, the report noted that most of the steps intended to increase

[85] Medicare Payment Advisory Commission, Report to Congress, Medical Savings Accounts and the Medicare Program, November 2000, p. 19.(http://www.medpac.gov/).

participation would "decrease beneficiary protection or increase the financial risk to the Medicare program."[86]

7.4 Proposals for MSAs in Hong Kong

In December 2000, the Hong Kong government released a consultation document on health care reform entitled *Lifelong Investment in Health.*[87] Acknowledging that the sustainability of Hong Kong's health care system is "highly questionable", the document puts forward a three-pronged strategy for ensuring the system's long-term financial sustainability. The third prong, after reducing costs/enhancing productivity and revamping the fee structure, is the introduction of MSAs called "Health Protection Accounts".[88] Health Protection Accounts will have the following key features:

- the creation of a personal account for the individual and the spouse comprised of mandatory contributions by the individual of one to two per cent of earnings from age 40 to 64;
- savings cannot normally be withdrawn from the account until the person reaches 65;
- on withdrawal, the savings can only be used for the person's or spouse's medical and dental care, based on public sector rates, or to purchase medical and dental insurance from private insurers;
- if a person chooses services in the private sector, he or she will be reimbursed at public sector rates from the accumulated savings, any price difference will have to be met from the person's resources outside the savings accounts or from private insurance;
- on death, unspent savings left in the account will be passed on to the surviving family.[89]

The purpose of the Health Protection Account is to assist "individuals to pay for heavily subsidized medical services after retirement, and not to shift the burden to the next generations".[90] To keep the savings rate at an affordable level, the proposal limits withdrawals from the account until age 65 and after and provides for reimbursement of costs at public sector rates. The government estimates that for a family at a median income level, based on the average utilization rate, a couple will be able pay for medical expenditures at public sector rates up to the average life expectancy age.[91] The Hong Kong government intends to conduct a further study of the merits and feasibility of Health Protection Accounts in 2001-2002.

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[86] *Ibid.*

[87] Hong Kong, Lifelong Investment in Health, Consultation Document on Health Care Reform, December 2000. (http://www.info.gov.hk/hwb/english/CONSULT/HCR/HCR2.HTM#Contents).

[88] *Ibid.*, p. 51.

[89] *Ibid.*, p. 57.

[90] *Ibid.*, p. 58.

[91] *Ibid.*

For individuals who have saved very little or who have exhausted their savings because of frequent illness, the paper makes brief reference to (but does not detail) a second "safety net" provided by the government.

To deal with individuals requiring long term nursing care, however, the consultation document mentions a proposal for a separate personal savings account, "Medisage", with contributions from the individual at the rate of 1% of salary to purchase long-term care insurance upon retirement. Because long-term care insurance is not well developed in Hong Kong, the government proposes to conduct more in-depth studies of options for long-term care and the features of the scheme. [92]

7.5 MSAS: the Debate

There is no consensus among experts on the impact of MSAs on health status and on health care costs. On the one hand, proponents maintain that MSAs increase consumer choice, encourage patients to make more prudent use of health services and reduce health care spending. MSA opponents, on the other hand, contend that MSAs can realize only small health care savings at best, segment the risk in the insurance market, drive up insurance costs for those remaining in comprehensive plans and have an adverse impact on health as people, particularly the poor and unhealthy, cut back on necessary health care.

Could a system of MSAs be implemented in Canada? A study authored by University of Calgary health economists, Cam Donaldson, Gillian Currie and Craig Mitton, pointed out that the task in Canada would not be particularly easy. In their view, there are practical problems associated with implementation and other structural issues that would have to be addressed before any benefits associated with MSAs could be realized. First, the advantages of consumer choice associated with MSAs might be limited in the Canadian context because Canadians already have considerable leeway in choosing their doctors and specialists. Similarly, MSAs might have a limited impact on encouraging Canadians to invest in their own health choices because Canadians can already make many of these investments. [93]

Donaldson, Currie and Mitton mentioned the problem of "asymmetrical information" as another limit on the possibility for gain from MSAs. Many consumers may have difficulty making informed decisions about their health care because they lack the appropriate information. In addition, the ability of consumers to become active health care consumers may vary across age and socioeconomic groups. [94] Finally, they stressed that if governments were to allocate their health care dollars to MSAs, health care spending would remain the same. With money in MSAs, however, consumers may demand more and better access to services but the system may not be able to accommodate those increased demands and expectations. Their study concluded by suggesting that "valid and reliable piloting of

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[92] *Ibid.*, pp. 58-59.
[93] *Ibid.*
[94] Ibid., p. 20.

the medical savings account model in a Canadian setting would certainly be required before fully informed judgments about its impact can be made."[95]

[95] Ibid.

CHAPTER EIGHT:

COMPARATIVE ANALYSIS

During Phase Three, the Committee was made aware of substantial differences among countries in what they each cover under their public health care insurance programs and how these programs are funded. Health care systems also differ in terms of the role of private insurance and patient responsibility for paying part of their health care expenses. We learned that all health care systems are hybrids: they have a combination of public and private involvement in financing and delivering health care. The characteristics of each health care system also vary from country to country depending on their political economy and structure of government, as well as on the values of their respective society.

Despite these differences, most countries want similar things from their health care system: effective services that improve the health and quality of life of their citizens, equitable access to those services, and efficient use of health care resources. In pursuing those goals, however, different countries have taken very different paths. Moreover, choosing one direction over another has always entailed trade-offs. As Dr. James Björkman from the International Institute of Social Studies of the Netherlands eloquently put it:

> *(...) there are three criteria sought by all health care systems that I know of. These criteria are summed up in the quest for the highest quality care at the lowest reasonable cost for as many people as possible. In other words, policy-makers seek to improve access and to assure quality at the same time as ensuring cost-effectiveness.*
>
> *Problematically, however, these three pull in different directions – that is, to get more of one usually entails getting less of others. The search is for the right combination appropriate for a particular country at a point in time.* [96]

8.1 Financing And Coverage

As stated above, there are substantial differences among the countries considered in the Committee's study in terms of what is covered under their publicly funded health care system and how it is financed.

Our international comparative study indicated that the most comprehensive publicly financed health care systems are found in Germany, Sweden and the United Kingdom. The public share of total health care spending is greater in these three countries (with 84% in Sweden and the United Kingdom and 75% in Germany) than in Canada (70%).

[96] Dr. James Björkman (15:4).

Many countries with a similar share of public health care spending to Canada – such as Australia and the Netherlands – also provide coverage that is much broader than is available in Canada. This has usually been achieved with the participation of the private sector either through the imposition of user charges or the involvement of private health care insurance.

> *[One] difference relates to what is covered publicly. In Canada, the public financing of the system is focused on hospitals and doctors. In many other countries, public financing extends much more into pharmaceuticals. I am not sure what the implications of that are for efficiency, but there are certainly implications of that with respect to equity and access to needed care.*
>
> *Cam Donaldson, Professor, Department of Economics, University of Calgary (22:17)*

In contrast to Canada, however, user charges for publicly insured health services are required in Australia, Germany, the Netherlands and the United Kingdom. Even in Sweden, which is generally recognized as being amongst the most socialized of the European countries, user charges are required for publicly funded services. Furthermore, private health care insurance that covers the same benefits as public insurance is available in many countries, while it is not in Canada.[97] For example, in Germany and the Netherlands, private health care insurance is voluntary for those people with an annual income over a certain level (public health care coverage is mandatory for those with low incomes). In those countries private insurers must accept all those who apply for coverage and must provide benefits equivalent to those offered under the public plan. In Australia and Sweden, government legislation requires that premiums charged by private health care insurers be community-rated (i.e. a single premium structure applies to everyone regardless of their health status). The Australian government actively encourages residents to acquire private health care insurance by subsidizing 30% of its cost. In the United Kingdom, as in Australia, residents can purchase private insurance to cover services provided in private hospitals as well as in public hospitals.

> *Differences also arise with respect to the extent to the two-tier system in different countries. In the U.K., everyone is locked into paying for the system. In Canada we pay through our taxes. However, unlike Canada, the U.K. has no restrictions on private purchase of publicly insured services. That is always portrayed as a great thing about the Canadian system, but one of the paradoxes is that in the U.K. only 10 per cent to 15 per cent of expenditures come from the private purse: in Canada that figure is 25 per cent. Therefore, what you have here is a different form of the two-tier system. It just covers a different set of services.*
>
> *Cam Donaldson, Professor, Department of Economics, University of Calgary (22:17)*

The evidence suggests that a contribution of direct payments by patients, allowing private insurance to cover some services, even in publicly funded hospitals, and an expanded role for the private sector in the delivery of health services are the factors which have enabled countries to achieve broader coverage of health services for all their citizens. Some countries like Australia and Singapore openly encourage private sector participation as a means to ensure affordable and sustainable health services.

[97] No single country relies exclusively on private insurance to provide health care coverage to its citizens. Even in the United States, where the private sector is a dominant player in the field of health care insurance, public funding accounts for 45% of total health care spending. The fact is that health care is different from other marketable goods and services.

With respect to user charges, Ake Blomqvist suggested that, while it would be difficult to start requiring direct partial payments from patients for physician and hospital services in Canada, these charges could help raise revenue to pay for an expanded basket of publicly-funded health services:

> *(...) I have come to the conclusion that we will never have a rational debate about user fees in Canada. The concept of user fees has become a symbol in the federal-provincial jostling over power in health care policy. We are all better off giving up on the idea of user fees for physician services and hospital services.*
>
> *If, however, we expand the concept of Medicare to include publicly funded Pharmacare, and perhaps long-term care and home care as well, then I believe that the issue of user fees must be re-examined. I do not think that there is an example of a country that covers pharmaceuticals and long-term care that does not have some degree of patient co-payment.* [98]

By contrast, Mark Stabile stressed that while Canada has the opportunity to improve access to care and equity by expanding coverage to include other areas of health services not previously publicly funded, this will come at a trade off, probably in terms of Canada no longer offering first dollar coverage for all hospital and doctor services. [99]

In addition to the variations in public coverage, the health care insurance plans in the comparison countries also differ greatly in the sources of government revenue that are used to fund the public share of total health care spending. In Australia, Canada and the United Kingdom, public funding is largely derived from general tax revenue, while in Germany and the Netherlands most of the public funds allocated to health care are raised by the social insurance system through employers' and employees' contributions. In Sweden and Singapore, public funding for health care is generated from a combination of both general taxation and social insurance.

Are there particular lessons for Canada in the experience with the different approaches to health care funding in other countries? According to Ake Blomqvist, countries with a single payer health care system seem to better contain overall health care costs. In his view, it is worth considering the possibility of extending public health care coverage in Canada, while maintaining the single-payer principle:

> (...) those countries whose systems most closely approach the principle of single-payer public funding, (...), also are those that devote the lowest share of GDP to health care costs. While Canada strictly respects the single-payer principle with respect to the services covered under the Canada Health Act, the fact that the range of benefits that is covered is relatively narrow means that, in reality, we have a mixed system with a relatively high degree of reliance on private funding. Thus if cost containment is a main objective,

[98] Ake Blomqvist (22:22-23).
[99] Mark Stabile, E-mail to the Committee, June 2001.

there would seem to be a prima facie case for extending public sector coverage to encompass a broader range of benefits, for example, by introducing a system of publicly funded Pharmacare, as suggested by the National Forum on Health.[100]

8.2 Primary Care

Perhaps the most interesting differences among the health care systems of industrialized countries reviewed by the Committee pertain to the way primary care is supplied and, in particular, the incentives to which primary care providers are subject.

In Canada, Australia and Germany, as well as in the original Medicare plan in the United States, the predominant form of delivery remains through general practitioners (family doctors) who operate as solo practitioners, and are paid through a fee-for-service scheme. From the viewpoint of patients, a valued feature of the fee-for-service remune n scheme is that it places no significant restrictions on their choice of doctors. Critics of such a system say that it gives doctors incentives to provide many short visits, but no incentives – in fact disincentives – to fix multiple problems in one visit, or to provide education or counselling activities at the same time. Put simply, doctors who choose to have longer visits, and hence treat fewer patients daily, see in effect their remuneration reduced.

In contrast, primary care in the Netherlands and in many managed-care plans under American Medicare, is provided by general practitioners whose income is based on capitation, working in solo or group practices. Capitation funding, as the name suggests, is a per capita method of compensation. The amount of revenue a general practitioner receives is based on the amount of patients he/she treats, regardless of the number of visits. One advantage of capitation funding is that it encourages doctors to devote more time to their patients. Capitation, however, carries an incentive to under-service because payment is unrelated to the quantity of services provided. Moreover, a system of capitation that requires individuals to enrol with one particular general practitioner or group of health care providers reduces a patient's freedom to choose his/her own health care provider.

One of the attractive properties of a capitation system is that it can be modified to incorporate incentives for primary care physicians to make cost-effective decisions with respect to the use of a wide range of health care inputs (drugs, specialists, hospital services, diagnostic testing). The experience with GP Fundholding in the United Kingdom, and their recent transformation into Primary Care Groups, provides useful guidance in this regard. General practitioners involved in Primary Care Groups receive a mixture of remuneration including capitation, salary and fee-for-service (for selected items). It has been suggested that this combination of types of payment ensures an effective provision and utilization of health services.

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[100] Ake Blomqvist, International Health System Comparisons: Lessons for Canada, Brief to the Committee, June 2001, p. 4.

According to Ake Blomqvist[101], the fact that capitation has been widely used for a long time in the Netherlands means that its workability in providing cost-effective care is well established. The increasing importance of managed-care plans with capitated primary care providers in the United States, not only under the Medicare plan but in the general population as well, is further evidence in favour of its potential attractiveness. In Blomqvist's view, the capitation alternative should be given serious consideration as a central element in primary care reform in Canada. He also stressed that the United Kingdom experience clearly illustrates that it is possible to have a system in which capitation, salary and fee-for-service exist side by side, as alternative ways of paying for primary care.

Sweden is an outlier among the countries reviewed by the Committee in that most of its general practitioners are salaried. Under this salary mechanism, Swedish doctors are paid an annual income unrelated to their workload. The most common argument against salary remuneration is that providers tend to be unresponsive to their patients' needs. The main advantage of salary remuneration is that it does not encourage doctors to over-service patients by providing unnecessary care. The Committee was told that general practitioners in Sweden receive an overall level of remuneration that is lower than many other industrialized countries.

Overall, it seems that all remuneration methods create both desirable behaviour and undesirable behaviour. In this perspective, a number of Canadian experts believe that a blended system for remunerating family doctors, incorporating elements of fee-for-service and capitation and/or salary, would be more appropriate than one single payment mechanism.

However, the Committee was told that fee-for-service is a major impediment to primary care reform in Canada. According to Cam Donaldson:

> *The big difference here compared to many other countries is the remuneration of physicians. To me, this is a great barrier to reforming the system. I personally think that maintaining a fee-for-service form of remuneration is inconsistent with moving to a purchaser-provider model. I do not think that a purchaser-provider model will work with a fee-for-service form of remuneration.*[102]

8.3 Integration of Health Services

In contrast to a number of countries, the different elements of Canada's health care system are not well integrated financially. Separate financing means that the various health care providers and institutions tend not to take account of the costs and benefits of their actions to the system as a whole. According to Donaldson, Currie and Mitton, this lack

[101] Ake Blomqvist, *International Health System Comparisons: Lessons for Canada*, Brief to the Committee, June 2001, p. 5.
[102] Cam Donaldson (22:18).

of financial integration has led to «perverse incentives» within the Canadian health care system.[103]

For example, regional health authorities and health care providers (hospitals, hospital doctors, and primary care doctors) in Canada very often act independently from each other and are remunerated separately. Consequently, they do not face the same incentives with respect to achieving common goals for the publicly financed health care system.

Regional health authorities do not have enough control of health care resources within their jurisdictions. First, doctors are remunerated independently of health authorities. Second, it is doctors who direct much of what happens in health care, but health authorities must pick up the tab. For example, when a physician orders a lab test or an X-ray, it is the health authority that carries the financial burden. If health authorities had control over the budget currently used to pay for doctors, the behaviour of both doctors and authorities would be more in line with each other. According to Donaldson, Currie and Mitton, some form of internal market or purchaser/provider split, as adopted in Sweden and the United Kingdom, could do this.

In Canada, the separation of the purchaser and provider function in the hospital sector already exists. In the past, purchasers have been the provincial ministries of health, with whom hospitals have negotiated their annual funding. In many provinces, the purchasing function is now being decentralized to regional health authorities which, in many ways, are in a position similar to the District Health Authorities in the United Kingdom in the 1990s (or to the county councils in the Swedish health care system).

International experience shows that accepting the principle of a purchaser-provider split would not imply significant change in Canada. The key is to be careful about the way the contracts between purchasers and providers are written and enforced, to whom the purchasers are accountable, and the incentives to which they are subject.

One element of such a reform would be to include the cost of physician services in the regional authorities' budgets, as has been done in Sweden. According to Ake Blomqvist, giving regional health authorities control over the aggregate cost of both hospitals and physician services would greatly strengthen their ability to make rational decisions about how to allocate their resources most effectively to promote population health.[104]

Could greater financial integration of Canada's health care system be achieved by putting health care money in the hands of patients themselves through a system of MSAs? As Chapter 7 indicated, MSAs would make health care consumers more active participants in health care spending decisions. However, Donaldson, Currie and Mitton cautioned that: "Valid and reliable piloting of the medical savings account model in a

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[103] Cam Donaldson, Gillian Currie, Craig Mitton, C.D. Howe Institute Commentary, *Integrating Canada's Dis-Integrated Health Care System, Lessons from Abroad*, No. 151, April 2001.

[104] Ake Blomqvist, Brief to the Committee, p. 9.

Canadian setting would certainly be required before fully informed judgements about its impact can be made."[105]

8.4 Role of Government

Among the countries reviewed by the Committee, Canada is unique in that the central level of government plays a very small direct role in the delivery of health care. Under the Canadian Constitution, health care is a matter of provincial/territorial jurisdiction except in the case of some groups of people, the most important being the First Nations and the Inuit. Historically, the federal government, at a time when its share of overall health care spending was more important than it is now, had a controlling influence on the development of the Canadian health care delivery system which culminated in the *Canada Health Act.*

Given Canada's political structure, most analysts agreed that it would be difficult to adopt the approach taken by other countries to reform their health care system. Carolyn Hughes Tuohy pointed to three strategies for enacting and implementing health care reform:

> *A big bang approach to health care reform is very politically risky and it is rare that any government will take that chance. It requires a confluence or convergence of political developments that is very rare. You must be able to consolidate political authority on a fairly massive scale and you must have the political will to take the risk. To the extent that you consolidate authority, you also consolidate accountability, which then makes it more difficult to shift the blame to someone else.*
>
> *We have seen big bang reforms on rare occasions. We saw it in Britain after the Second World War with the establishment of the NHS. We saw it in 1980s in Britain with the Thatcher government in its third successive majority mandate. These are rare events.*
>
> *Blueprint-type reforms are more likely in coalition circumstances where bipartisan compromise is necessary. I have not mentioned certain U.S. states where we also saw blueprint approaches because of the need for bipartisan compromise - with a similar result as that in the Netherlands. Things tended to stall or get rolled back as the complexion of the political coalition changed over time.*
>
> *In Australia and Canada we have seen incremental reforms where federal-provincial consensus cannot be mobilized for something broader. That, also, is a*

[105] Donaldson, Currie and Mitton, p. 20.

result of factors in the broad political arena and not in the health care arena itself. [106]

Overall, proposals for a "big bang" overhaul of Canada's health care system would be difficult. Nonetheless, major changes are needed if the hopes and aspirations of Canadians are to be met.

Claude Forget, a former health minister in Quebec and an acknowledged expert on comparative health care systems, told the Committee that international experience should alert us to the dangers of a public system that is held hostage to the vagaries of political life, and that therefore fails to sustain a pragmatic, managerial approach to health care reform:

> *It appears that there are many instances of practical solutions being attempted [in Western Europe]. However, those systems are closely related with the political lives of their respective country means that the attempts are fragile. These experiments are not sustained, even when successful.*
>
> *I would not condemn any system for attempting new solutions and changing its mind when new solutions are not effective. However, this has not been the case. The closeness of the system to the political life of the country means that ideological reasons are the cause of the system's failure.*
>
> *We [in Canada] share that habit to some extent. It should alert us to the danger of a public system that is held hostage by the vagaries of political life. When the health care system is tied to the political system it fails to sustain a pragmatic, managerial approach to problem solving.* [107]

[106] Carolyn Tuohy (22:28).

[107] Claude Forget (22:14)

CONCLUSION

This report completes Phase Three of the Committee's study on health care. It summarizes the evidence we heard and makes reference to documents that were either commissioned by the Committee or brought to the attention of the Members.

Canadians may find some consolation in the fact that Canada is not alone in confronting complex health care issues. Everywhere in the industrialized world health care policy is thoroughly interwined with the political, social, and even cultural life of each country. As such, every health care system is unique. Therefore, no single international model constitutes a blueprint for solving the challenges confronted by the Canadian health care system. However, experts told the Committee that careful consideration must be given to the repercussions in Canada of introducing, on a piecemeal basis, changes undertaken in other countries.

In its Phase Four report released recently, the Committee stressed the importance of adopting an open-minded approach to health care reform, and of considering the full range of available options, including those gleaned from the experience gained elsewhere in the world. We hope that this report will serve as a useful document to anyone who wishes to participate in the fifth and final phase of the Committee's study on health care – the set of public hearings which will lead to the Committee's final recommendations.

APPENDIX A:

LIST OF WITNESSES

Monday, May 28, 2001
(By videoconference)

From the Ministry of Health, Welfare and Sports of the Netherlands:
Dr. Hugo Hurts, Deputy Director, Health Insurance Division, Ministry of Health, Welfare and Sports of the Netherlands

From the International Institute of Social Studies of the Netherlands:
Professor James Bjorkman

Thursday, June 7, 2001 (9:00 a.m.)
(by videoconference)

Swedish Parliament (Riksdag):
Lars Elinderson, Deputy member, Committee on Health and Welfare

Monday, June 11, 2001
(By videoconference)

German Health Ministry:
Georg Baum, Director General, Head of Directorate Health Care
Dr. Margot Faelker, Deputy-Director, Section Financial Issues of Statutory Health Insurance
Dr. Rudolf Vollmer, Director-General, Head of Directorate Long-Term Nursing Care Insurance

Department of Health – Economic and Operational Research Division of the United Kingdon:
Clive Smee, Chief Economic Adviser

University of Birmingham:
Professor Chris Ham, Director, Health Services Management Centre

London School of Economics:
Professor Julien LeGrand, Richard Titmuss Professor of Social Policy, LSE Health & Social Care

Tuesday, June 12, 2001
(By videoconference)

Australian Institute of Health and Welfare:
Dr. Richard Madden, Director

Australian Health Insurance Association:
Russel Schneider, CEO

National Centre for Epidemiology and Population Health – Australian National University
Dr. Tony Adams, Professor of Public Health

Health Insurance Commission:
Dr. Brian Richards

Tuesday, June 12, 2001 (cont'd)

Australian Medical Association:
Dr. Carmel Martin, Director
Dr. Roger Kilham

Wednesday, June 13, 2001

Health Canada:
Ake Blomqvist, Visiting Academic, Applied Research and Analysis Directorate, Information, Analysis and Connectivity Branch and Professor, University of Western Ontario

University of Calgary:
Professor Cam Donaldson, Department of Economics

University of Toronto (by videoconference):
Professor Colleen Flood, Faculty of Law

As an individual:
Claude Forget

University of Toronto:
Professor Mark Stabile, Department of Economics
Professor Carolyn Tuohy, Department of Political Science

Thursday, June 14, 2001
(by videoconference)

U.S. Department of Health and Human Services:
Christine Schmidt, Deputy to the Deputy Assistant Secretary for Health Policy, Office of the Assistant Secretary for Planning and Evaluation
Ariel Winter, Analyst
Tanya Alteras, Analyst

APPENDIX B:

HEALTH CARE SPENDING, HEALTH CARE RESOURCES AND HEALTH STATUS : COMPARATIVE DATA, 1998

	SPENDING ON HEALTH CARE		PUBLIC HEALTH CARE SPENDING		HEALTH CARE RESOURCES		HEALTH STATUS INDICATORS	
	As a % of Gross Domestic Product	Dollars per Capita at Purchasing Power Parity	As a % of Total Health Care Spending	As a % of Gross Domestic Product	*Acute Care Beds* (per 1,000 population)	Practising Physicians (per 1,000 population)	*Life Expectancy at Birth* (in years)	*Infant Mortality Rate* (per 1,000 of live births)
Australia	8.5	2,043	69.3	5.9	4.0[1]	2.5[1]	78.3	5.0
Canada	9.5	2,312	69.6	6.6	2.9[1]	2.1	79.1	5.5[1]
Germany	10.6	2,424	74.6	7.9	7.1	3.5	77.3	4.7
Netherlands	8.6	2,070	70.4	6.0	3.7	n.a.	78.0	5.2
Sweden	8.4	1,746	83.8	7.0	2.7	3.1[2]	78.7	3.6[1]
United Kingdom	6.7	1,461	83.7	5.6	2.4	1.7	77.3	5.7
United States	13.6	4,178	44.7	6.1	3.2	2.7	76.8	7.2[1]

PPP: Purchasing power parity.
n.a.: Non available.
1) 1997 data.
2) 1996 data.
Source : OECD Health Data (2000), United Nations (for life expectancy), and Library of Parliament.